Please Type or Print in Black Indelible Ink Stanley Kevin Marsh State of Maryland / Department of Health and Mental Hygiene 1- For State 2005 Certificate of Death Registrar Amend#5. Per Fam. PGC 6-21-06 cr Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 8, 2006 Medical Examiner Stanley Kevin Marsh 0225 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Country Hospital Cheverly Prince George's **Funeral** 5. Social Security Number 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 577-15-6846 Foreign Months Director Davs Hours Min 1x M 2 6468 Yrs 28 18,1978Washington,D.C April Usual Residence of Decedent AUV 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits items 23a or 28a-f show 1 X Yes 2 No . Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mornal Hygiene are the fired page 23a or 28a-f sho rant: If tien 27 is marked other than "natural", or items 23a or 28a-f sho or other tranmatic event, the Medical Examiner must be notified as once. Washington D.C. rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 듑 218 Tennessee Ave. N.E. 20002 United States Funeral Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black Armed Forces? 1 Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Yes If Yes, Give Year Widowed Divorced Yes 2X No specify Specify: **Black** ≥ 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 Cement Driver Private 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Stanley Marsh, Sr. Lynell Booker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynell Marsh / Mother 5620 Lansing Dr. Temple Hills, Md. 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 Cremation 3 crematory or other place) Removal from State Baltimol permit. Pages Department of Important: 1 Lincoln Memorial June 14,2006 Suitland, Md. Donation 5 22. Name and Address of Facility
Alexander S. Pope Funeral Homes, Md. A. 20747 21. Signature of Funeral Ser 0105 Part I. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. Between Onset and (Medical a. Multiple Gunshot Wounds Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death
To the Funeral Director: After this certificate has been signed by the attending physician and and Physician/Medical attending physician or use as the burial -UNPENDED AMENDED Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknowr ned by the a detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 No ✓ Yes 2 No 25. Was case referred to medica 26 Place of Death (Check only one) Division of Vital Be examiner? Other 4 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 1 🗸 Yes 2 Residence 6 Other No 28a. Date of Injury (Month, Day,Year) Jun 7, 2006 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject was shot 1 Natural 2330 hrs of ih by the fi Yes 2 V No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 4217 Quinn Street, Capitol Heights, MD determined 4 V Homicide (Specify) Single Family 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical

30 Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner

and manner stated.

111 Penn Street, Baltimore, MD 21201

29c License number

O.C.M.E.

29d Date signed (Month, Day, Year)

June 8, 2006

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day Year)
JUN 1 6 2006 State Registru

29b. Signature and title of certifier

one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20502 1 - State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Willie Mae Mathis June 13, 2006 6:27p /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6604 Arlene Dr. Capitol Heights Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🖾 F 127-22-5564 81 Director June 1925 Sumter, Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits ehow. r than "nature!, or items 23a or 28a-f ehov The Madical Examiner must be notified at Maryland Prince Georges Capitol Heights Director Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6604 Arlene Dr. 20743 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelih and Mental Hygiene. Important: If itsm 27 is marked other than "naturel" or iten eny injury or other treumatic event, the Medical Exercipations. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2€ No Specify: Specify: Black Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12 Food Nutrition Specialist Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Dargan Hester Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cheryl Jordan / Daughter 12715 Lampton Lane Ft. Washington, Md. 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial June 19,2006 Suitland, Md. 21. Signature of Funerat Service Licen Name and Address of Facility Alexander S. Pope Funeral Homes, P.A. 5538 Mariboro Pike/Forestville, Md. 20747 23a. Part f. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimers Disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Lisease or in any that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): physicien end the burial-transit Due to (or as a consequence of): IF FEMALE: esn 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 TyYes 2 □ No Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.
I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) determined 4 - Homicide To the Hospital within 24 hours a To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

The law requires that the death certificate be executed

Box 68760

P.0.

Division of Vital Records,

Hospital or Attanding Physician:

the Maryland

deeth with

Baltimore, Maryland 21215-0036

State Registrar

31. Date liled (Month, Day, Year) JUN 1 6 2006

Emerson Coronell, M.D.

(cause of death (Item 23a) (Type, Print)

M0051194

5801 Allentown Rd. S-510 Camp Springs, Md. 20746

June 15, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20503 State of Maryland / Department of Health and Mental Hygiene 2 () () 1- State Amend Item 28e per ME, G857, 07/26/06dhb of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 10,2006 2030 Iwao Milton Moriyama 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Hospital Prince Prince Georges Cheverly Georges Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day. Year) Hours 1 X M 2 □ F 97 Yrs. /26/1909 224-60-1647 San Francisco,CA Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1X Yes 2 No Maryland Prince George's Mitchellville 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number 10450 Lottsford Road 20721 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 21 No Specify: Specify: Asian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coflege (1-4or 5+) Elementary/Secondary (0-12) Biostatistician 4+ Health 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Suburo Moriyama Reki Moriyama 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Halley I. Moriyama - Son 4 Tappan Rd., Wellesley, MA 02482 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 6/15/2006 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Fineral Service Licensee 4739 Baltimore Ave., Hyattsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEMATOMA resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23d. Date of delivery ic pregnancy Month Dav r (specify) ing cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autonsy performed? 1 Yes 2 No

Exami or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Funeral Director: After

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Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 3 ☐ Ectop 4 ☐ Pregnant at time of death 5 ☐ Othe 9 ☐ Unknown
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nner of Death Natural 5 Pendir Accident investi	ng igation	28a. Date of fnjury (Month, Day Year) June 4, 2001	28b. Time of Injury	c. Injury at Work? 1 ☐ Yes 2 ☑ No	28d. Describe how injury occurre						
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	at home	Road	Mitchelville	MARYLA
29a. Certifier	1 Certifying Physician: To the best of my knowledge, death occurred at the time,	date and place, and due to the	e cause(s) and manner as sta	ated.
(Check only	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion	on, death occurred at the time	, date and place, and due to	the cause(s)
one)	and manner stated.			

(Check only one) 2 **Médical Examiner: On the basis of examination and/or and manner stated.	r investigation, in my opinion, death occurred at the	e time, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
29b. Signature and title of certifier and Affectes Drie	D57636	6-13-06
30. Name and address of person who completed cause of death (ftem 23a) (Type		1
PATRICIA EBEN, MD 3001 -	HOSPITKL DRIVE	CHEVERLY, MD 20785

31. Date filed (Month, Day, Year) 32. Registrar's Signatur JUN 1 6

State

Registrar

			For State	State of Ma	aryland	/ Depa	rtment of He	ealth and M			05	20504
3	2 4		1. Decedent's Name (First, Middle, La	st)		001	inicate of L	- Calii	2. Date of Dea	eg. No. ,	- No.	3. Time of Death
п	Physici		_	W. Morgan					Month June	Day 1.2 2	Year 2006	4:18 A M
	/Medic Examin	23 6	4a. Facility Name (If not institution, giv				4b. City, Town, or	Location of Death	June	4c. County		4:10 A
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Maryland 21215-0036	2 sho and le ma		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street a	nd Number or Aur	al Route Numbe	r, City or Town,	State, Zip	Code)
2	and ealth m 27		Raquel M. Smit	h/Daughter			09 Christ		Ct., To			
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Baltimore,	permit. Pages 1 and 2 s Department of Health ar Importent: If Item 27 le eny Injury or other trau Once.		21. Signature Fundral Service Lice	Steval	L.III		. Name and Address 4001	s of Facility Benning I	Stewart Rd., NE			
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene UU 0

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					Cer	tificate of	Death		Reg. No.		
			1. Decedent's Name (First, Middle, Lest)					2. Date of De Month		3. Ti	me of Death
	Physici		William H. Maul	tsbv. Jr.				June	Day 9		:00AM
	/Medic		4a. Facility Name (If not institution, give street				4b. City, Town, or				. 0 0111
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th	9. Birthplace (S Country)	
	Director		203-09-4765 IXIM	2□ F 8	4 Yrs.	Months Days	Hours Min.			North C	arolina
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	yłany Pow		10a. State 10b. County	10c. 0	City, Town or Lo-	cation				10d. ins	ide City Limits
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	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?	<u> </u>
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	deatl	Funeral	11. Marital Status 12.	Was Decedent Ever in	U,S. 13. V	Vas Decedent of H	dispanic Origin? (S an, Mexican, Puerl	pecify Yes or No		e - American Indi	
0	ifer and	Ē		Armed Forces? ▼ Yes 2 □ No f Yes, Give				o rican, etc.)	10000	k, White, etc.	
21215-0020	72 hours after death with the Maryland neturel; or items 23e or 28e4 show diest Examinar must be molified at	þ	3 Widowed 4 Divorced	f Yes, Give rear or Dates:	1	I□Yes 2√∑No	Specify:		Specify	· Blac	k
Ò	n 72 hours "neturel", edical Eva	Completed	15. Decedent's Education	n ,	16a. Deced	lent's Usual Occup	ation	el e la co	16b. Kind of Bu	isiness/Industry	
2	C . 69	pie	(Specify only highest grade co	прієтеа) College (1-4or 5+)	life. [DO NOT use retire	during most of word)	King			
21		E	12th	50g5 (1	į	Postal	Carrier		Go	overnmen	t
ō	al Hygie other i	BeC	17. Father's Name (First, Middle, Last)					ne (First, Middle	Maiden Surnam		
<u>a</u>	d be ental ked o	To B	William H. Mault	shy. Sr.				.Io	anna Has	rang	
Maryland	d 2 should be filed thend Mental Hyg 7 Is marked other treumatic event,	-	19a. Informant's Name/Relationship (Type,		19b. Mailin	g Address (Street	and Number or Ru	***************************************			
ž	Ithen Ithen 27 Isr		Tanya M. Daughtry	/Daughter	3	22 T St.	, NW Was	sh., DC	20001		
ā,	Pages 1 end 2 nent of Health Int: If Item 27 Is Iry or other tre		20a. Method of Disposition		Place of Dispos	sition (Name of	1	Date	20c. Location -	City or Town, Sta	ate
Baltimore,	ages intof i: If II		1 ABurial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)		•	natory or other pla		(107/00	4 9 •		
≣	it. P rtani njuri		21. Signative of Fûneral Service Licensee			On Nation Name end Addre	nal Cem.			ngton, V	A
Ba	permit. Pag Department Important: I eny Injury o		21. Signature of Authoral Service Liberises	- A -	1				Funeral		
			John S	eward, I			Benning H		-	JC 20019	
			23a. Part1. Priter the disease, or complication shock, or heart failure. List only one complications are complicated to the complex of the co	ons that caused the dea	ath. Do not ente	er the mode of dyir	ng, such as cardiad	or respiratory a	rrest,	Interva	ximate al Between
N.	Physician	1				0				Onset	and Death
4	/Medical		Immediate Couse (Final disease or condition	581	JER G		4 Eums	MIA			
	Examiner	Ų.	resulting in death)	Due to	(or as e conseq	uence of):					
	p #	Examiner		C	O ACG	ur of A	7147			į	
	certificete be executed Iding physician end Ise es the buriel-transit	E	Sequentially list conditions, if any, leading to immediate	Due to	(or as a consequ	uence ol).	Force	200		-	
Ö,	cerificete be execul rding physician end ise es the buriel-trar		cause. Enter Underlying Cause (Disease or injury	02_	Cody		777C	ALCE		!	
68760,	hysic the t	√Medicai	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):	7	2			
9 x c	ing p	¥.	L d	17 (ab	, nov	100	1 prox	7020	2		
	ath cert ttendin or use										
<u>.</u>	e de the e	Sic	Part II. Other significent conditions contribu	ting to death but not re	sulting in the un	derlying cause giv	en in Part I.	23b. Did	tobecco use cor	tribute to the ce	use of death?
P.O.	d by letac	Physicia	Coronam a	rtory	Oli 76	ese		1 🗆	Yes 2□ No	3 Probably	4 Umknown
Ś.	es the digner	۵		-				-			
or o	equir een s ould	te						24a. Was perfo	en autopsy med?	24b. Were auto eveilable p	prior to
Ö	ew r	pie l								of death?	n of cause
œ	The late h	Completed						10	res 2 No	1 ☐ Yes	2□ No
ita	en: riffice stor,	Be	25. Was case referred to medical				26. Place of Dea	th (Check only o	ne)		
>	ysic Is ce direc	70	exeminer? 1 Yes 2 No Hosp	^{tal:} 1□Inpatient 2[☐ ER/Outpetient	t 3□ DOA Oth	ner: 4 Nursing H	ome 5 Resid	dence 6 □Othe	er (Specify)	
0	Attending Physicien: The lew requires that the death extremels. scrot-selt. scrot-selt. by the funeral director, page 2 should be detached for		27. Manner of Death	Ba. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injur Wor	y at	28d. Describe I	now injury occurr	ed	
<u>ō</u>	eth.	atic	2 Accident investigation	(, 22)	,,		Yes 2 DNO				
	Atte er de recto by th	ti ti	3 ☐ Suicide 6 ☐ Could not be determined 2	Be. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (S City or Tox		er or Rural Route	Number,
ō	Bed in	Certification:		zzz.i.g, oto. (opeo				5, 0 0	,,		
	the Hospital or Attending Physicien: The lew requires that the death hin 24 hours efter death. The second set of the second of the second of the second of the etter of the second of t		29a. Certifier 1 Certifying Physicie 2 Medical Exeminer:								use(s)
	ithin 24 the Fi	ledical	one)	and manner stated.							
	ا المعارفة	Σ	29b. Signature and little of certilier		1-00	29c. Licens	e number	,		i (Month, Day, Y∈ √I	ear)
^	100				WO	17 (0721)	P111	00	
1	1201		30. Name and address of person who comple	ted cause of death (Ite					_		
X			HZEEZ MB	10000	7207	Hanover 1	Parkway,	Greenbe	lt, MD	20708	
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Sign	nature	٠.					
	Registr	ar	JUN 1 6 2006	Older S	E DON'S						

DHMH 16 Rev 6/95

			For State Registrar	State of Maryland /	Certific			Re	g. No.	10	20000
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Ye	ar	3. Time of Death
	/Medic			illard					, 2006		12:15A ^M
)	Examin	er	4a. Facility Name (If not institution, give s				r Location of Death		4c. County of I		
			Futurecare Pine				linton	To D. (Did	Prince		
	Funeral		5. Social Security Number 6. Sex	M 2DTE		nder 1 Year ths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.		ce (State or Foreign
	Director		578-50-4722	87	113.			Aug.17	, 1918	Wa	sh.,DC
	and w		10a. State 10b. County	10c. City, To	wn or Location	1				100	I. Inside City Limits
	Aaryl Pho	ŏ	MD. PG	For	t Wash	nina+	on				1√⊒Yes 2 □ No
	28e-	ect	10e. Street and Number	101		f. Zip Code	011	10	g. Citizen of Wha	t Country	u?
	with a or	ᅙ	3016 Melisa Dri	170	10	2074	1				
	death with the Maryland me 23a or 28e-f ehow r nust be notified at	Funeral Director		2. Was Decedent Ever in U.S.	13 Was D				Jnited 14. Race -		
		'n	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ∑No	If Yes,	specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Vhite, et	
5	rs ef	by	3 ⅓Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 🗆 Y	es 2∏ No	Specify:		Specify:	B1ac	7 k
2-003b	filed within 72 hours efter death with the Marylan Hygiene. Ither then "naturelt, or iteme 23a or 28e-f show int, the Marical Examiner must be notified at		15. Decedent's Educ	eation 16	a. Decedent's	Usual Occup	pation	1	6b. Kind of Busin		
5	in 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind o	of work done OT use retire	during most of work d)	ring			•
77	iene rthe	E O	7		Teache	rs Ai	ide		Day Ca	re (Center
0		Be C	17. Father's Name (First, Middle, Last)	<u> </u>				e (First, Middle, M			
	id be lental ked c	ToB	Mayo Delaney				Ruth Th	omas			
	d 2 should th and Men 7 ie marke treumatic	_	19a. Informant's Name/Relationship (Typ	oe, Print)	9b. Mailing Add	iress (Street	and Number or Rur	al Route Number,	City or Town, Sta	te, Zip C	ode)
Z	c = 0 -		Grace Gordon/da	ughter	3016 M	elişa	a Drive	m 207/	1.4		
ค์	- 1 2 2		20a. Method of Disposition	come	of Disposition tery, crematory	(IVallie UI		Date 2	0c. Location - Cit	y or Town	n, State
Ê			1 🖾 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	rrecti			4/06	linton	. MI	D.
Бапт	permit. Page Depertment of important: if any injury or once.	-	21. Signature of Funeral Service License				ss of Facility HC			-	
ñ	Den Pany Pany Pany		Manico Ca	Inviole			ver Hill				
			23a. Par 1. Enter the disease, or complic	cations that caused the death. De						A	pproximate
	Dhisiss		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	2 0 1		Culmo	24 014 44	Ances	1- 6	nterval Between Inset and Death
) '	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	-4		womo	navoj 1	7 0 0	1	
	Examiner			Dae to tor as a consequence	Mesa	stil	e He	art	Fra (a	14	
		e	if any, leading to immediate	Due to (or as a consequence	e of):						
	uted ansit	듵	cause. Enter Underlying Cause (Disease or injury that initiated events	Rosan	Cla	a	AST	hma			
<u>,</u>	exec n and ial-tra	Examiner	resulting in death) Last	Due to (or as a consequence	e of):						
04/8	icate be executed physicien and s the burial-transIt	dicat		2+8	UKe						
										1	
ŏ	eath certifi attending for use as	N	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy					23d. Date of	fdelivery	
'n	death s atte d for	icla	in the past 12 months? 1 ☐ Yes 2 ☐ X No	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		oic pregnancy or (specify)	y 		Month	D	ay Year
2	at the de by the a tached t	Physician/M	9 Unknown	9□ Unknown							
<u>.</u>	The law requires that the death certif te hes been signed by the attending page 2 should be detached for use a	by P	Part II. Other significant conditions con	tributing to death but not resulting	in the underly	ing cause giv	ven in Part I.	23e. Did toba	acco use contribu	te lo the	cause of death?
cords,	n sig	D D		relife				1 ☐ Yes	2 ∑ No 3 [Probab	ily 4 □Unknown
္ပ	w require been sign	Completed		0				24a. Was an	24b. Wer	e autops	y findings available
ě Ľ	The law cete hes page 2 s	Ę,						autopsy perform	ed? prior	r to comp th?	eletion of cause of
		O O	25. Was case referred to medical							Yes 2	No -
5	eicie certi	00	examiner?	ospital:	2	Oth		h (Check only one			
0	Phys rthis raldi	5	27. Manner of Death	-	Outpatient 3	28c. Injur	^{ner:} 4 [x]Nursing Ho v at	28d. Describe how		Specify)	
Division	th. th. : After s funer	ţ	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	28c. Injur Wor 1 🗆	rk? Yes 2∐No		. ,		
<u></u>	Attending Physicien: or death. octor: After this certific by the funeral director.	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home,	farm, street, fa	ctory, office		28f. Location (Stre	et and Number o	r Rural F	Route Number,
=	2550	Certification:	4 Homicide	building, etc. (Specify)		•		City or Town,	State)		
	To the Hospital of within 24 hours at To the Funerel Completely filled in		29a. Certifier 1 Certifying Phys	ician: To the best of my knowled	lge, death occu	rred at the til	me, date and place,	and due to the car	use(s) and manne	r as state	ed.
	ne Hc	Medical	(Check only 2 Medical Examination)	er: On the basis of examination and manner stated.	and/or investiga	ation, in my d	pinion, death occur	red at the time, dat	te and place, and	due to th	ne cause(s)
	To the within 2 To the complet	×	29b. Signature and title of certifier	2 setten 20	5.1	29c. Licens	se number	29	d. Date signed (N	fonth, Da	y, Year)
			1 June- H.	5 Marine Cl	\mathcal{A}^{\prime} .	DOG	1242	38	6.13	} -	2006
0	(2)		30. Name and address of person who co	mpleted cause of death (Item 23)	Type, Printf	300	10/00-	Mari	DOC.	-0	160:
1	0		ABYCHASAN	ANSHRI	01	41	s will	21	50,0	<u> </u>	Tt 'U(
	THE RESERVE	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	-11	10	V) IVI		133		

DHMH 17 Rev 1/2001

				1- For State of Maryland / Department of H Certificate of I			jiene eg. No.	06	20507
		Physici /Medic		1. Decedent's Name (First, Middle, Last) Estelle Randolph Meyers		2. Date of Dea Month June	Day	Year 2006	3. Time of Death 3:05 A. M
		Examir		4a. Fecility Name (If not institution, give street and number) Suburban Hospital 4b. City, Town, or Bethese	or Location of Death da	1		y of Death tgome	
		Funeral Director		5. Social Security Number 085-18-2310 6. Sex 1 M 2 F 82 Yrs. 7. Age (In yrs. last birthday) Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb 11	, 1924	9. Birth Cou Ind	place (State or Foreign Intry) 1a
		the Maryland 28a-f ehow	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Kensington					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
		oth with the h 23s or 28s-i	Direct	10e. Street and Number 10f. Zip Code 5209 Strathmore Avenue 2	20895	10g. Citizen of What United S			•
	980	vithin 72 hours after dee ne. hen "naturel", or Items e Madical Examiner m	To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No Yes, Give Yes, Give Yes, or Dates:		pecify Yes or No- Rican, etc.) 14. Race - American Black, White, etc. Specify: Whit		etc.	
	21215-0036		completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occup. (Give kind of work done of life. DO NOT use retired Sales	vation during most of work d)	of working 16b. Kind of Busing Retail			ndustry
	Maryland	uld be file Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Innes Randolph	18. Mother's Nam Dorothy	ne (First, Middle, i y Mann	Maiden Suma	me)	
		permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 le marked other t eny injury go other traumatic event, in		19a. Informant's Name/Relationship (Type, Print) Daniel Meyers/ Husband 19b. Mailing Address (Street of 5209 Strathmo)	and Number or Rui ore Avenue	ral Route Number e, Kensi	ngton, l	n, State, Zij MD 2	0895
	Baltimore,	Pages 1 and of He		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of Georgian Translation of Central Part of Center Medical Center	ity June	6 ¹³	^{20c.} Location Washin	gton	D.C.
	Balt	permit. Departr Importe eny inju		21 Signature of Fun ral Service License 22. Name and Address P. O. Box 5	ss of FacilityCO1	umbia Mo hington,	rtuary D.C.	Serv 20037	rices, Inc.
4	1	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Adenocarcinoma Due to (or as a consequence of):				6	Approximate Interval Between Onset and Death Weeks
	8760,	Hospital or Attending Physician: The law requires that the deeth certificate be executed by hours effer death. Funeral Director: After this certificate has been signed by the attending physician and telling filled in by the funeral director, page 2 should be detached for use as the burnat-transit by	dical Examiner	Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					
5080 90	P.O. Box 68	it the deeth certifica by the attending ph lached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown	<i>'</i>			ate of deliv	ery Day Year
6112106		n requires thet the deett been signed by the atte should be detached for	d by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Peripheral Vascular Disease	en in Part I.				he cause of death?
R	of Vital Records,	The law require has been age 2 should	omplet	Thrombosis left Internal Jugular and Axillary Hypertension, Chronic Obstructive Pulmonary Di		24a. Was a autops perform	n 24b.	Were auto	opsy findings available ompletion of cause of
15	Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Deat	th (Check only on	(e)		2□ No
Estelle		ding Phys h. After this funeral di	tlon: To	27. Manner of Death 1 ♣ Inpatient 2 ⊨ Ev/Outpatient 3 ⊨ DOA 27. Manner of Death 1 ♣ Inpatient 2 ⊨ Ev/Outpatient 3 ⊨ DOA 28b. Time of Injury Work (Month, Day Year) 28b. Time of Injury	4 Nursing Ho	ome 5 Reside 28d. Describe ho			(y)
	Division	if or Attendi efter death. Director: A d in by the fu	Certification; To	2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (St City or Town	reet and Num n, State)	ber or Rura	al Route Number.
Meyers		To the Hospital or Attending Physician: The within 24 hours effect death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check ordy one) Certifying Physicien: To the best of my knowledge, death occurred at the time (Check ordy one) Medicat Examiner: On the basis of examination and/or investigation, in my open and manner stated.	ne, date and place, pinion, death occur	, and due to the carred at the time, d	ause(s) and m ate and place,	anner as s and due t	stated. o the cause(s)
7		To the within 2 To the complet	Ž	29b. Signature and title of certifier 29c. License D2111.			9d. Date signe June 12		
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lee R. Pennington, M.D. 10215 Bethe	Fernwood sda, MD	d Road 20817			
		Sta Registi		JUN 1 5 2008 32. Registrar's Signature					

			1 - For State Registrar	State of Maryland		rtment of He			giene Reg. No.	6 20503
			Decedent's Name (First, Middle, Last))				2. Date of Dea		3. Time of Death
	Physicia		Donald E	· Magrud	0,			Month Tune		Year 11:00P M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or L	ocation of Deeth	UUIIG	4c. County of	
	LAGIIIII	CI	13715 Village Mil	1 Drive		Maugansy	ville			rington
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day		Birthulace (State or Foreign Country)
	Director		212-20-1276	M 2□F 80	Yrs.			Aug. 29	9, 1925	Maryland
	p ,		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation				10d. Inside City Limits
	aryla shov	5	Maryland Washing			sville				1 □Yes 2 □ No
	Ne M	Director	10e. Street and Number	,con n	augani	10f. Zip Code			10g. Citizen of W	
	with t		13715 Village Mil	1 Drivo		2176	7		U.S.	Λ
	ss 23	Funeral	13/13 VIIIage FIII	12. Was Decedent Ever in U.S	i. 13. V	Vas Decedent of His Yes, specify Cuban		ecify Yes or No-		- American Indian,
	ter d	E	1 Never Married 2 Married	Armed Forces? 1 ⊠Yes 2 ☐ No				Rican, etc.)		c, White, etc.
936	urs al	by	3 ☑Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: WWII	•	☐Yes 2∏XNo	Specify:		Specify:	White
Ŏ	2 ho	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	lent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of work	ing	16b. Kind of Bus	siness/Industry
2	thin 7	ng l	Elementary/Secondary (0-12)	College (1-4or 5+)					0.5	G t T
2	filed within 72 hours after death with the Maryland Hyglene. Uther than "natural", or Items 23a or 28e-f show that the Medical Examiner must be modified at		10 17. Father's Name (First, Middle, Last)		51	ore Manag	18. Mother's Nam	e (First Middle		Stores, Inc.
and Pure	be fi	Be		dow			Bessi		a11	•
ž	2 should be and Mental Is marked o	ဥ	Maurice Magrue 19a. Informant's Name/Relationship (7)		19b. Mailir	a Address (Street ar				State, Zip Code) 21771
Maryland 21215-0036	77 7		Donna Bowman - Day							Maryland
	1 and 2 Health tem 27 i		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of natory or other place		Date		City or Town, State
ᅙ	ages ant of ht: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donateo 5 ☐ Other (Specify	Removal from State	•	Memorial	1	/17/06	Rockvil	le, Maryland
Baltimore,	permit. Pages 1 am Department of Healt Importent: If item 2 any injury or other 2005e.		21. Sign ture of Funeral Service Licens) 22	. Name and Address	s of Facility			•
B	Per		Hourt L.	Killian		olesworth				
			23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of	plications that caused the death.	. Do not ent	er the mode of dying	e ROAD such as cardiac	vanascy	Sest, Mary L	
	Physician		Immediate Cause (Final disease or condition	(3)	1110	DISEASE				Onset and Death UNOSTERMINE
П	/Medical		resulting in death)	Due to (or as a consequ		P S P S P				
	Examiner		Sequentially list conditions,	b						
	p ii	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ						
	ecute and -trans	Examiner	that initiated events resulting in death) Last	cDue to (or as a consequ	ence of):					
60,	ate be executed obysician and the burial-transit	E		200 (0) (0) 40 4 00 (10)						
8760,		dical		d						
9 X	death certific e attending p od for use as	/Me	IF FEMALE:	23c. If yes, outcome of pregnar					23d. Date	e of delivery
Вох	atter i for u	ciar	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2□Fetal 4□Pregnant at time of de		Ectopic pregnancy Other (specify)			Mor	nth Day Year
Ö	that the death cert ed by the attendin detached for use	nysi	9 Unknown	9□ Unknown						
s, P	requires that the een signed by th hould be detache	Y P	Part II. Other significent conditions of	ontributing to death but not resu	Iting in the u	nderlying cause give	n in Part I.	23e. Did t	/	ibute to the cause of death?
rds	quire an sig uld b	ed to	CEREBROVASCI	KAN ACCIOS	<~/7			1 🗆 `	Yes 2 ☑ No	3 Probably 4 Unknown
of Vital Record	aw requir	Completed by Physician/Me	CHRONIC OB	STINCTIVE	PUL	nowany	DISTAS.	24a. Was	psy p	Vere autopsy findings available irior to completion of cause of
ŭ	The law ate has b page 2 sl	EO		•				perfo	rmed2 d	leath? ☐ Yes 2 ☑ No
ita		BeC	25. Was case referred to medical examiner?		112		26. Place of Dea	th Check on	one	
> =	S 0 0	2	1 ☐ Yes 2 ☑ No		ER/Outpatier		4 Nursing H		dence 6 Othe	
	ng P		27. Manner of Death 1 Watural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work		28d. Describe	how injury occurre	ea
sio	Attending or death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		mo form at		res 2□No	28f Location (Street and Number	er or Rural Route Number,
Division	or At after of Direct in by	Certification:	4 Homicide determined	building, etc. (Specify		eet, lactory, office		City or To		
ш	Hospitei 24 hours 2 Funeral I tely filled		29a. Certifier 1 Certifying Ph	ysicien: To the best of my know	wledge, deat	h occurred at the tim	e, date and place	, and due to the	cause(s) and ma	nner as stated.
	To the Hospitel or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	edical	(Check only 2 Medicel Examone)	niner: On the basis of examinat and manner stated.	tion and/or in	vestigation, in my op	inion, death occu	rred at the time,	date and place, a	and due to the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier			29c. License	number		-	i (Month, Day, Year)
			Welling 80	Duneto mo		00	05139	5	06/1	5/2006
ln	+1		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)				2/2006 2/742
			William E. Ray	5761 M.Q. 11110	MEDIO	ar campo	US 720, 5	V17E10), HAGE	15 Jan, MO
	St Regist	ate trar	31. Date filed (Month, Day, Year) JUN 1	32. Registrate Signat	J. K	Soule				
	ricgisi		4 0011 1	O many bearing						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		ryland / Depa <i>Cei</i>	artment of H		F	leg. No.	3 2 1 5 0 9
П	Physici	an	Decedent's Name (First, Middle, L.					2. Date of Dea Month	ith Day Yee	3. Time of Death
	/Medic	al	Theda Mae 4a. Facility Name (If not institution, gi	Miller		Ab Cib. Town	1	June	12, 2006	
	Examin	er				4b. City, Town, or		n	4c. County of De	
	Funeral		7908 Longmeadow 5. Social Security Number 6.		(In yrs. last birthday)	If Under 1 Year	erick II Under 24 Hrs	8. Date of Birth	Frede	erick Birthplace (State or Foreign
ı	Funeral Director		-	1 □ M 2 🛣 F	81 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	13, 1925	Country) West
	ס		Usual Residence of Decedent						10, 11, 13	Virginia
	ylan		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	a-1 s	cto	Maryland Frederi	LCK	Frederic	K				1 ☐ Yes 2 No
	or 28	lre	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	th wi	al	7908 Longmeadow I)rive		21701			U.S.A.	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, I're Medical Examinal must be neitlind at ODGe.	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	Was Decedent of Hi If Yes, specify Cuba 1 Yes 21 No		pecify Yes or No- o Rican, etc.)	14. Race - Ar Black, Wi Specify:	merican Indian, hite, etc. white
5	72 h	etec	15. Decedent's E (Specify onfy highest gi	ducation rade completed)	16a. Deced	dent's Usual Occupa	ation during most of wo	rkina	16b. Kind of Busines	ss/Industry
7	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	-)	kind of work done of DO NOT use retired)		0 1	
7	ygier ygier her th		10		Homem	aker			Own hor	ne
Maryland 21215-0036	ould be fil Mental H arked otl	To Be C	17. Father's Name (First, Middle, Las James Mathias	t)				ne (First, Middle, na Shipe	,	
, Mar	and 2 sho alth and 127 Is mu er trauma		19a. Informant's Name/Relationship Frances Miller -						r, City or Town, State	. Zip Code) 1and 21702
Baltimore,	ages 1 ant of He it: If item		20a. Method of Disposition 1 □ XBurial 2 □ Cremation 3 (1 □ Cremation 5 □ Other (Spec		20b. Place of Dispo cemetery, cren Resthaven				20c. Location - City	
₹	artme orten injur		21. Signature of Funeral Service			2. Name and Address				
ä	Dep Puri	10	Sharm (a)	nillo E	//				Funeral Hoderick, Ma	ome aryland 21702
and the	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List only timediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a	PULMOM consequence of):			c or respiratory arr	est,	Approximate Interval Between Onset and Death
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Decado of highly that initiated events resulting in death) Last	с.	consequence of):					
O. Box	ath cert	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Petal death 3□	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
Δ.	ures that the de signed by the a d be detached f	by	Part II. Other significant conditions	contributing to death but	t not resulting in the u	nderlying cause give	en in Part I.			to the cause of death?
Ö	w require been sign	ete		(2/03/0/0	-					
Vital Records,		Completed						24a. Was a autops perform	ried? prior to med? death?	autopsy findings available ocompletion of cause of ?
/its	ilclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	11		La		th (Check only on	10)	
1	this of all dire	은	1 Yes 2 No		t 2 ER/Outpatien		4 Nursing H		ence 6 Other (Sp	necify)
<u>_</u>	ding Phys h. After this funeral di	on	27. Manner of Death 1. □ Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Work		28d. Describe ho	ow injury occurred	
Division of	deatl deatl stor: , the	Certification:	2 Accident investigation 3 Suicide 6 Could not I 4 Homicide determined	De Place of frie	ry - At home, larm, stre (Specify)		∕es 2 □ No	28f. Location (St City or Town	reet and Number or in, State)	Rural Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Directompletely filled in by	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysicien: To the best of miner: On the basis of and marmer stat	examination and/or inv	occurred at the tim vestigation, in my op	e, date and place sinion, death occu	, and due to the carred at the time, d	ause(s) and manner ate and place, and di	as stated. ue to the cause(s)
	vithin orth	Me	29b. Signature and title of certifier	7/		29c. License	number	2	9d. Date signed (Moi	nth, Day, Year)
	C->0		· \	U,	0	0	32171		6/12/	loc
	7		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type.		7-111		6/(2/	
	3		RICHARD GUUG	0 0		ALKEESU	LIE MA	21753		
F	Sta			2006 32. Poistrar	's Signatur	Coole		21/13		

DHMH 17 Rev 1/2001

06-04028

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Eric Eugene Muller 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ June 12, 2006 1000 hrs Me Eric Eugene Muller Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Westminister Carroll Carroll County Hospital Center 5. Social Security Number 7. Age (in yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Min. Director Country) Mary land 220-90-3651 30 Jan.21, 1976 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits my 10a. State 10b. County 10c. City. Town or Location 1 XYes 2 No 28a-f show Carroll Westminster Maryland death with the Maryland Director s 23a or 28a-f e notified at o 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country 76 Pennsylvania Ave. 21157 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes White Yes 2 X No specify: 3 Widowed If Yes, Give Year Specify: 4 X Divorced <u>چ</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed permit. Pages 1 and 2 should be filed within 721
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nijury or other framments. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 11 woodworker furniture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph Eugene Muller Debra Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Muller/ former wife Union Bridge, MD 21791 301 E. Thomas St. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 6/23/2006 Union Bridge, MD Mountain View Cem. Donation 5 Other Specify. Swhour Funeral Service Licens 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval /sician Between Onset and failure. List only one cause on each line. edical Death Narcotic (Heroin) intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical item#23a,PII,27,28a-f,perME,g857,7/15/06 TI X UNPENDED AMENDED signed by the attending physician be detached for use as the burial the Hospital or Attending Physician: The law requires that the death certificate be bin 24 hours after death. The faure the Funeral Director: After this certificate has been signed by the attending physicia pletely filled in by the funeral director, page 2 should be detached for use as the burian Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Cocaine use Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 1 🗸 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 Other ို 1 ✓ Yes No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural Yes 2 No Pending 6/10/2006 1:00 am ıınk 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) / Pennsylvania Ave. Westminster, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 X Could not be Suicide (Specify) residence determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical Phedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number certifie June 14, 2006 O.C.M.E. WJL 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Susan Hogan MD. 111 Penn Street, Baltimore, MD 21201

State

31. Date filed (Month, Day, Year) JUN 2 6

2006

State of Maryland / Department of Health and Mental Hygiene [] [] [5] Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 25, Ralph Lee Munson 2006 4:00 A. June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington 13840 Exline Road Hancock If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) December 17,1938 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months **™** M 2□ F 67 Yrs. Μ̈́D 220-34-0999 Director Usuel Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10h County in than "natural", or items 23s or 28e-f show the Medical Examiner must be collified at 1 ☐ Yes 2 ☑ No **Funeral Director** Washington Hancock 10g, Citizen of What Country? 10e, Street and Number 10f Zin Code 21750 **USA** 13840 Exline Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1964–1970 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If tem 27 is marked other than "natural", or itsa any injury or other traumating any injury or other traumating and 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Metal Fabrication Laborer 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Magdalene Potts Norman R. Munson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13840 Exline Road Hancock, MD 21750 Karin Ingrid Gerda Munson/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 06/26/06 Smithsburg, MD 21 Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Small /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical for use as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ed bluods 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nasidence 6 Other (Specify) 1□Yes 2⊠No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 1 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No M death. 2 Accident after death 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier -16-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cunper MedFeel

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 9

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) ^{Day} 2006 Year **Physician** MANDRACCHIA June 11, 7:45 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 10803 Howard Terrace Beltsville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. August 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2XF 16, 1920 New York 85 Yrs. 081-16-0968 Director Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28a-f ehow the Madical Examinar must be notified at 1 Yes 2 No Directo Beltsville Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20705 United States 10803 Howard Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 end 2 should be filed v Department of Health and Mental Hygier important: if I tem 27 ie marked other tr eny Injury or other treumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Montalbano (1997) Guardino Maria Salvatore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 10803 Howard Terrace, Beltsville, Maryland 20705 Stephanie A. Porto, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

WBurial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State St. Mary's Cemetery June 15, 2006 Rye Brook, New York 4 □Donation 5 □ Other (Specify) 21. Signature of Funera Service Licensee Dönald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road, Beltsville, MD 20705 23a. Part1. Effet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebrovascular Accident /Medical Oue to (or as a consequence of): Examiner Failure to Thrive Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ettending physicien and for use as the buriat-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) cete has been signed by the page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2X) No 1 ☐ Yes 2X No : After this certifice funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home St Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Oescribe how injury occurred nours after death.
neral Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 □Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide To the Hospital of within 24 hours at To the Funeral Discompletely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DY 7428 June 12, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lila M. Bahadori, M.D. 10301 Georgia Ave. #304, Silver Spring, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 14 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) **Physician** 8 McCafferty 2006 10:00 p M June E. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel 4308 Molly Shippen Trail West River Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 ☐ M 2 🗓 F 76 577-36-2445 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ir then "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes XXNo Anne Arundel West River MD Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20778 USA 4308 Molly Shippen Trail Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Nursing LPN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hisent: If Item 27 le marked off lury or other traumatic even Hugh A. O'Boyle Alice B. Duffy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bridget Young (Daughter) 1340 Sweet Pea Path, Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXeurial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any Injury or QDCC. 6-12-2006 West River, MD Our Lady of Sorrows 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) ned by the e 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed d be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 22 No 2 □ No 1 ☐ Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this ierel Director: After the 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours efter To the Funerel Dire Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month! Day, Year) 29b. Signature and little of certifier who completed cause of death (Item 23a) (Type, Pring egistrar's Signature 31. Date filed (Month State

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Registrar

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 5:30 A™ Mary Helen McDonald June 12 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel 610 Americana Drive, Apt. 106 Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Nov. 28, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year) **Funeral** Days 1 M 2 XF 92 578-32-1093 Yrs 1913 Washington, DC Director Usual Residence of Decedent the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location 28a-f show other treumatic svent, the Medical Examiner must be notified at Annapolis Maryland Anne Arundel ¥OXYes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 21403 610 Americana Drive, Apt. 106 U.S.A. or items 23a death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. e filed within 72 hours after of Hygiene.

Other then "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. White Specify: ğ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Executive Administrative Asst. Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny injury or other treumatic svent once. Be Rene Eugene Fraile Elizabeth Margaret Callahan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathleen Stone/niece 1205 Roundhill Road Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 6/14/2006 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Breast Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificete 1 Yes 2 No To the Hospital or Attending Physicien: within 24 hours after death.
To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only ope, Be Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 210 No 1 _ fnpatient Certification: To 1 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature nd title of certific one 12,2006 who completed cause of death (ftem 23a) (Type, Print) Svite . Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 3 2006 Registrar

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	2	230 Oignature and		den	ζ /l	/\		200	O.C.M					8, 200		, Day, 1 July	
-3-						anth (ltar-	232)							, 200			
0		30. Name and add Susan Hog		n who complet Assistant			23a) 111 Pei	nn Stree	t, Baltir	mpre, M	ID 212	01					
9	tate					's Signate		19 -									\dashv
Regis			UN 14	2005		0 10											- 1

06-04013

Loan Phuong Nguyen

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		- For State		·		Certifi	icate of	Death				Reg	. N o.	4	JUE	2 4 1	0.1
Physician		I. Decedent's Name (First, Middl	e,Last)									ate of Death Month	Day	Year	3	Time of Death	h
Medical Examine	54 4			Phuor	ig Lo	an T.	Nguy	en			J	une 11, 20	006		Doodle	1552 hrs	
	4	4a. Facility Name (if not institution Aqua Land Marina	n, give s	treet and nu	umber)		4	o. City, To Newb l		ocation of	Death			ounty of Irles	Death		
Funeral	Ę	5. Social Security Number	6. Sex	-	7. Age (Ir	n yrs. last b	oirthday)	If Under		If Under		Date of Birth	(MM/DD/			lace (State or	
Director		216-71-8523	1N	2 X F		21	Yrs.	Months	Days	Hours	Min.	Dec 29,	, 198		Foreign Cour	try) Viet	nam
>		Usual Residence of Decedent 10a. State 10b. County			100	c City Toy	wn or Locatio	ın						_	1	Od. Inside City	Limits
Maryland 28a-f show any d at once.	- 1					o. ony, 101	mir or Ecourio		· ^	: 11	_					1 X Yes 2	
yland t-f sh	ĕŀ	Maryland Prince To e. Street and Number	e G	orge	5		1	10f. Zip (svill	<u>.e</u>	100	. Citizen	of Wha	at Countr	y?	
_ F &	Director	6401 Landover	Roa	ad #T3	3				2078	35			7	/iet	nam		
ms 23a	era	11. Marital Status		12. Was De		er in U.S.					n? (Specif	y Yes or No- an, etc.)	14.	Race - White,		an Indian, 8lack	۲,
er death	Funeral		arried	1 Yes Yes, Give Ye	2 X	No		Yes 2≸					Spe	ecify:	Asia	า	
urs afte	ᆰ	15. Decedent's Education (Spe		r Dates:		eted) 16	a. Decedent	s Usual C	 occupatio	on (Give k			16b. Kind				-
66 n 72 hou nan "nan ical Exa	ete 	Elementary/Secondary (0-12)		College (1-4 or 5+)						use retired)						
5-0036 lled within 72 hours al Hygiene Ingene in an "natural the Medical Examin	Completed	9th					Nail _	Tech			No. of the last	st, Middle, Ma			vate		
	ပ္ပို	17. Father's Name (First, Middle Nhung Nan Ngu										i Nguy		mame)			
D 21215-0036 should be filed within 7 is marked other than 1 ratic event, the Medica	P Be	19a. Informant's Name/Relations	-	e, Print)			19b. Mailing	Address			-	Route Numb		or Town	State, 2	Zip Code)	
e, MD 2 1 and 2 shou Health and P Titem 27 is r rr traumatic	-1	Phan Nguyen	(Und	cle)		- 1	6401	Land	over	Road	1, #T					20785	;
imore, MD 2121 Pages 1 and 2 should be fi ment of Health and Mental lant: If Yiem 27 is marked or other traumatic event.		20a. Method of Disposition 1 Burial 2 X Crematio		Bomoval f	rom State		ce of Disposit		e of ceme	etery,	Da	ate	20c. Loc	ation - (City or T	own, State	
MOI Pages ient of innt: B		4 Donation 5 Other S		Removali	TOTT State	Ches	apeak									e, MD	
Baltimore, permit Pages I an Department of Hee Important: If ite injury or other tr	T	21. Signature of Funeral Service	License	е								n/IIale					
	1	23a.Dart I.Ohter the disease, o	complic	eations that	caused the	e death Do			-			, Lanh				Approximate I	Interval
Physician /Medical	100	failure. List only one cause	on each	n line.	00000	J dodnii. D			-,			,				Between Ons Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)	-	rowning ue to (or as	a consequ	uence of):									\neg	_	
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687 certific ding p		23b. Was decedent pregnant in the past 12 months?	he	1 Live		ne of death	2 Fet			Ectopic	pregnancy		Mo	onth	Da	y Ye	ar
Box 68' ne death certification the attending red for use as	Physicia	1 Yes 2 No 9 🗸 Ur	known	. =	nown		5 Oth	ner (Spec	ity)				1				
O. E		Part II. Other significant cond	tions o	contributing	to death b	ut not resu	ılting in the u	nderlying	cause gi	iven in Pa	rt I.	1		_		e cause of dea	
ires th.	d b														3.3	bly 4 🗸 Unk	
ords * request specific should	Completed											24a Was a autops	y	pr	ior to co	ppsy findings av mpletion of cau	
Recc The lavate ha	E											perform 1 Y Yes 2			eath? Yes	2	No
tal Rectian: The certificate ector, page	Bec	25 Was case referred to medic examiner?	_ ⊢						10		Check only						
With this call dire	힑	1 ✓ Yes 2 No	HC	spital: 1	Inpatient		R/Outpatient			other ₄	Nursing H	d. Describe h	Residence	L		Scene 	
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification:	27. Manner of Death 1 Natural 5 Per	nding		e of Injury th, Day,Year D:		8b. Time of Ir	ıjury 2		es 2 🗸	برجا	bject drow		occurre	u		
ISIO Atter er dear rector	icat	2 🗸 Accident Inv	estigation uld not b	28e Pla			552 hrs e, farm, stree	et, factory	office bu	uilding, et	c. 28			Numbe	r or Rura	Route Number	er, City
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e Hosp 124 ho e Fune etely f	al	29a. Certifier 1 Certifying	Physicia	n: To the be	est of my k	knowledge,	death occur	red at the	time, dat	te and pla	ice, and du	e to the cause	e(s) and n	nanner	as starte	d.	
To the within To the comple	ledical	one) 2 Medical Ex		On the basis and manner	s or examil stated	riation and	o investigat			aeath oc	oundu at (N	uate a				h, Day, Year)	- 1
	2	29b. Signature and title of certif	iei	1-				230	O.C.N				June 1			, Day, 16ai)	
(h)		I hardre	10	/ /	25	ath /ltom 2	20							_,			100.75
CLO		3 Name and address of person Theodore King MD.		ompleted ca stant Me			111 Pe	nn Stre	et, Bal	timore,	MD 212	01					5
St	ate	31 Date filed (Month, Day, Year)	7	Registrar's	Signature	Kan	6,					-				
Regist		JUN 1 4	2006	100	en	1	19										

			For State Registrar	State of Marylan		irtment of F			ene 2006	20518
	Physici /Medic		1. Decedent's Name (First, Middle, Last) CALVIN B. NEDD					2. Date of Death Month 06/02/2	Day Year	3. Time of Death 7:30 P M
>	Examin		4a. Facility Name (If not institution, give st				r Location of Death		4c. County of Dea	th
			BRADFORD OAKS NURS 5. Social Security Number 6. Sex		ast hirthday)	CLIN If Under 1 Year		R Date of Righ	PRINCE O	
	Funeral Director		253-62-3542 Usual Residence of Decedent	7. Age (In yrs. I	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 08/17/19	Year) Co 043 MAC	thplace (State or Foreign ountry) ON, GA
	Maryland I show	tor	10a. State 10b. County CHARLES C		, Town or Loc LDORF	cation				10d. Inside City Limits XX Yes 2 ☐ No
	h with the	ai Director	10e. Street and Number 136 GARNER AVENUE			10f. Zip Code 20602			g. Citizen of What Co	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Important: If Item 27 is marked other than "natural", or Items 23a or 28s-f show any injury or other traumatic avant, the Middeal Examinar must be notified at ance.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Moivorced	2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of H i Yes, specify Cub	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: BL.	te, etc.
Maryland 21215-0036	ithin 72 ho nan "natur Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0·12)	completed) College (1-4or 5+)	(Give life. D		pation during most of work d)	ing	6b. Kind of Business	/Industry
7	tygiar ther th		17. Father's Name (First, Middle, Last)	YEARS	TRUCK	DRIVER	18. Mother's Name		'RIVATE	
anc	ntail F) Be	REV. G.N. NEDD				VIRGINIA			
2	Should nd Me mark mark	ဥ	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street	and Number or Rura	al Route Number,	City or Town, State,	Zip Code)
	alth a		RODNEY T. NEDD / SO	ON	136 G	ARNER AV	ENUE	WALDORF	, MD 20602	2
ore,	of He		20a. Method of Disposition XXX Burial 2 ☐ Cremation 3 ☐ Re		lace of Disposemetery, crem	sition (Name of natory or other pla	(e)	Date 2	0c. Location - City or	Town, State
Ĕ	Pag ment ant: I		4 □Donation 5 □Other (Specify)	RES			TERY 06/0		CLINTON,	
Baltimore,	Depart Depart Import any in		21. Signature of Furnical Service Licensed	nshll					, MD 2074	OME OF MD, INC
ı			23a. Part . Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death cause on each line.	n. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate cause (Final disease or condition resulting in death)	HEPATOCELLUL	AR CAR	CINOMA				Onset and Death MONTHS
	/Medical Examiner		resorting in death)	Due to (or as a consequ	uence of):					
	*	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):					
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
60,	lificate be executed g physician end as the burial-transit	ai Ex	resulting in death) Last	Due to (or as a consequ	uence of):					
68760,	ficate physics the t	edicai	d.							
P.O. Box (death cer e attandin id for use	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnanc	,		23d. Date of de Month	livery Day Year
Ś	S C O	d by Ph	Part II. Other significant conditions cont	nbuting to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba		o the causa of death?
Division of Vital Record	The law ite has b page 2 s	Completed						24a. Was an autopsy perform 1 □ Yes 🏋	ed? prior to death?	utopsy findings available completion of cause of
/ita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death			
d	this at di	2	1 ☐ Yes XX No 27. Manner of Death	spital: 1 Inpatient 2			47_ANUrsing Ho		nce 6 Other (Spe	city)
5	ding h. After funer	tion	XXNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe hov	v injury occurred	
Divisi	i or Attanding after death. Diractor: After i in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre			28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) XX Certifying Physical Examination (Check only one)	cian: To the best of my knower: On the basis of examination and practices.	wledge, death tion and/or inv	occurrad at the tirestigation, in my c	me, date and place, pinion, death occurr	and due to the car red at the time, dat	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1		29c. Licens	e number	29	d. Date signed (Mont	h, Day, Year)
				7/		D1	9431		JUNE 07,	2006
R	(3)		30. Name and address of person who con FRANK M. RYAN, MD	pleted cause of death (Item 11701 LIVIN			WASHINGT	ON, MD 2	0744	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 3 2006	Registrar's Signa	Spee	Ev.		b		,

State of Maryland / Department of Health and Mental Hygiene, U 0 6 2051 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 13, Nolan, Jr. David 2006 8:48 P M Michael June /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park
If Under 1 Year If Under 24 Hrs. Montgomery 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min **X**□M 2□F Yrs. 63 Dec. 26, 1942 Washington, Director _DC 213-40-6257 Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show rthan "natural", or items 23a or 28a-f shov tre Medical Exempler must be putified at 1 XYes 2 No Directo Maryland Prince George's Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 4301 Queensbury Road 20781 USA Funeral 14. Race · American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene important: if item 27 is marked other than "natural; or ite important or other traumatic event, tra Middies Exemples once. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0·12) College (1-4or 5+) 2 Self-Employed Testing School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) David Michael Nolan, Sr. Margo Joyce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen P. Correal/ Daughter 23706 Grapevine Ridge Terrace, Clarksburg, MD 20871 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State June 15, 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2006 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis Address Collins Funeral Home Inc. Will Esson 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Infarctive Myocar dia **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☑ No 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown been si 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed this certificate 2 1 No 2 1 No 1 TYes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 PER/Outpatient 2 3□ DOA : After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Director: / investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospitei or At within 24 hours after o To the Funeral Direct 4 T Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Attending MD

Registrar DHMH 17 Rev 1/2001

State

Humayun 31. Date filed (Month, Day, Year) JUN 15

9

Emergency

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zeya M.D

2006

			For State	State of Maryland /	Department of Health and M Certificate of Death			U52U
			Registrar 1. Decedent's Name (First, Middle, L	astl	Certificate of Death	2. Date of Death		me of Death
	Physicia	an	Tychyo C	Northann	T	Month Da	Year X	:55 PM
	/Medic		4a. Facility Name (If not institution, gi	ive street and number)	4b. City, Town, or Location of Death		. County of Death	
	Examin	er	Coxety Hospi	. 1 11 1 1	Muchales	1	Micomic	
	Euporal		00201-111-11	Sex 7. Age (In yrs. last b	pirthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year	9. Birthplace (S	tate or Foreign
	Funeral Director		215-36-0055	10xm 2□F 66	Yrs. Months Days Hours Min.	6 18 19	The second second second	and
			Usual Residence of Decedent			- 	,	
	nylan how		10a. State 10b. County		wn or Location			ide City Limits Yes 2 □ No
	Be-1-	cto	MD Worces	ter To	comoke City		/	165 2 110
	or 28	Pire	10e. Street and Number	1	10f. Zip Code	10g. C	itizen of What Country?	
	n 72 hours after death with the Maryland "natural", or Items 23a or 28e-f ehow adical Examinar natal by trofilled at	Funeral Director	1932 Clari		2/83/		14. Race - American Indi	
	er de	nu	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	Black, White, etc	an,
9	hours after ural', or Ita	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	te
2-0036	hour		15. Decedent's		ia. Decedent's Usual Occupation	16b. l	(ind of Business/Industry	
က်	within 72 ene. than *nel	Completed	(Specify only highest g	rade completed)	(Give kind of work done during most of work life. DO NOT use retired)	ing		
7	1	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Police Officer	1	AW ENFOI	cement
ַ	be filed tal Hygid of other event, t	es	17. Father's Name (First, Middle, Las	st)	18. Mother's Nam	e (First, Middle, Maide	n Surname)	
land	Q 5 D .	To B	Irvin Co	rson Northa	m SR Mile	led.	Toxwell	
Mary	2 should and Men le marke eumatic		19a. Informant's Name/Relationship	(Type, Print) 19	9b. Mailing Address (Street and Number or Run	al Route Number, City	or Town, State, Zip Code)	
	5 = 12 T		Beverly Non	tham 1		omuke City	1,MD 218	51
or C	es 1 a of Hez f Item r othe		20a. Method of Disposition Disposition 3 Disposition 3	cemel	of Disposition (Name of tery, crematory or other place)	Date 20c.1	ocation - City or Town, Sta	ate
Ĕ	Pag nent int: I		4 □ Donation 5 □ Other (Spec		-BASTIST Cem 6/1	9/06 1	Ocomoke M	D
Baltimore,	permit. Pag Department Important: eny injury o		21. Signature of Funefal Service Lic	ensee	22. Name and Address of Facility	0 10	13 Lundan A	ve .
m	88 5 8	1	Muchyel A	Dean	Holloway Tureral Ho		occombile MD	21851
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death. Do	o not enter the mode of dying, such as cardiac	or respiratory arrest,	Interv	ximate al Between
·	Physician		Immediate Cause (Final disease or condition	Motostatio	Lum Cane	1	Onsei	t and Death
	/Medical		resulting in death)	Due to (or as a consequence	te of):			
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	D #	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	ce of):			
	and trans	Examine	that initiated events resulting in death) Last	c	no of):			
60,	cate be executed only sicien and the burial-transit	E		D 20 10 (31 40 4 001 00 q 201 10	ε σ.γ.			
87	physi the	dlcal	255	d				
9 ×	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of delivery	
Box	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal dea 4 Pregnant at time of death			Month Day	Year
o.	at the de by the a	ysle	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown				
٥.	res that igned by be deta	P P	Part II. Other significant conditions	contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the caus	se of death?
Records,	uires sign ld be	d by				1 X Yes	2 ☐ No 3 ☐ Probably	4 □Unknown
Ö	w require been si should t	Completed				24a. Was an	24b. Were autopsy fin	dings available
ě	he lay	Ę.				autopsy performed?	prior to completion death?	on of cause of
	n: Ti ficate or, pa		25. Was case referred to medical		26 Blood of Book	1 ☐ Yes 2 ☐ N h (Check only one)	o 1 ☐ Yes 2 ☑ N	-
Vital	rsicien: The law s certificate has t director, page 2 s	o Be	examiner?	Hospital: 1 Impatient 2 ER/6	Other	ome 5 Residence	6 Other (Specify)	
ō	~ .= 0	. To	27. Manner of Death	28a. Date of Injury 28b	D. Time of 28c. Injury at	28d. Describe how inj		
5	ading th. Afte	ē	Natural 5 Pending investigat	(Month, Day Year)	Injury Work? M 1 Yes 2 No			
Division of	Atter r dea ector by the	100	3 Suicide 6 Could no determine	286. Place of injury - At nome,	farm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route	e Number,
á	el or s afte l Dir	Certification:	4 Homicide	building, etc. (Specify)		Ony G TOWN, Sia	16)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific: completely filled in by the funeral director.				dge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur			auso(s)
	in 24 in 24 he Fi	Medical	one) @ Madical Ex	and manner stated.				
	Vith Tot com	Σ	29b. Signature and title of certifier	-1/N	29c. License number		ate signed (Month, Day, Y	
)			XX C	CH NN	006278		5-15-06	
5/	\ :;, \		30. Name and address of person wi	no completed cause of death (Item 23)	a) (Type, Print)		// ^ ^	16/27
51	1441		David E. Car		a) (Type, Print) el Hospin Po Box 1	133 50	ING MS F	180
	Sta Regist	ate	31. Date filed (Month, Day, Year) JUN 1 6	32. Redistrar's Signature	had.		\cup	
	negist	वा	3014 ± 0	LUVO KONSON JO	- Marie			

			1 - For State Registrar	State of Maryla		artmen <i>rtificat</i>			and M	ental H	lygie Rog	4, 0	06	20	521
			Decedent's Name (First, Middle, Last)							2. Date of				3. Time of	Death
	Physici /Medic		Gloria Erlaine Nor	cutt						Month June	12.	- ,	Year	6:56	P ^M
	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City,	Town, or	Location o	f Death			4c. County	of Death	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
			Montgomery Hospice	Casey House	2		Rocl	kvill	e			Mor	ntgor	mery	
	Funeral		Social Security Number 6. Sex	14 005	rs. last birthday)	If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of (Month) May 1	Birth Day Y	ear)	9. Birthp	place (State o	r Foreign
	Director		207-12-0245	IM 2反F 8	1 Yrs.	, , , , , , , , , , , , , , , , , , ,		110013		May 1	5,	1925	Vir	ginia	
	p .		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	nation								10d. Inside Cit	h. I imite
	anyla ehov	'n		100.										1 ☐ Yes	
	Ne M	Directo	Maryland Howard		Mount A	10f. Zir	0040				100	. Citizen of W	#5-10 O = 11		
	with t		17315 Pink Dogwood	Court		101. ZIÇ		21771				Inited		,	
	within 72 hours after death with the Maryland sne. then "natural", or Items 23s or 28s-1 show he Mudigal Examinar must be notified at	Funeral		12. Was Decedent Ever in	US 13	Was Dara			nin? (Sne	cify Yes or				can Indian,	
	Iter d	'n	1 Never Married 2 Married	Armed Forces?	0.0.	If Yes, spe	cify Cuba	n, Mexican	, Puerto I	cify Yes or Rican, etc.)	110		k, White,		
336	urs af	by	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2₩ No	Specify:				Specify:	Whi	ite	
Ş	2 hou	Completed	15. Decedent's Educ		16a. Dece				-1 -1:		16	b. Kind of Bus	siness/in	dustry	
75	hin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT u	se retired	during most)	t of workii	ng					
2	d wit giene er the	Ь	12		Homema	aker						Own H	lome		
9	al Hy f oth	Be	17. Father's Name (First, Middle, Last)									iden Sumame	a)		
<u>ā</u>	uld b Ment wrked write	To	John L. James						Lill:	ie God	lsey	<i>T</i>			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Itema 23a or 28e-f ehow any fujury or other traumatic event, the Mudical Extending mast be notified at anone.		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailir	ng Address	(Street a	and Numbe	r or Rura	l Route Nui	nber, C	City or Town, S	State, Zip	Code)	
≥,	and and mark		Lauren Norcutt / D					wood				y, MD			
ore	of H of H or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R		cemetery, crei	osition <i>(Nai</i> matory or c	ne of other place	θ)	June	14,	20	c. Location - (City or To	own, State	
Ě	Pag ment ent: ury c		4 □ Donation 5 □ Other (Specify)	Re	esthaver			cy i	200	06	Fr	ederic	k, M	arylan	ıd
at	epert epert poort ny Inj		21. Signature J Functial Service Lice J	99	Re	Name ar	d Addres	s of Facilit	al Se	ervice	es.	Skkot	Cody	P.A.	
_	#0 = # a	9.7	1/		195	01 Ca	atoct	in M	tn. I	lwy. I	red	<u>lerick,</u>	MD	21701	
			23a Part 1. Enter the disease, or cor pli shock, or heart failure. List or	mions that caused the de e cause on each line.	ath. Do not ent	ter the mod	e of dying	g, such as	cardiac o	r respirator	y arrest	,		Approximate Interval Bety	ween
4	Physician	ľ	Immediate Cause (Final disease or condition	Renal Cell	Cancer									Onset and D	eath
	/Medical		resulting in death)	Due to (or as a cons	equence of):										
	Examiner		Sequentially list conditions, b												×200
	D ti	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):										
	and -tran	кат	that initiated events resulting in death) Last	Due to (or as a cons	equation of):								-		
8760,	ate be executed thysicien and the burial-transit	E		Due to (01 43 4 00113	equence on).										
87	th y	dical	0				_								
9 ×	± on es	Physician/Me	IF FEMALE:	3c. If yes, outcome of pred	nancy							004 0-4-	-4 4-1		
Вох	eath cert ettendin for use	lan	in the past 12 months?	1 □Live birth 2 □ Fe	etal death 3	Ectopic po						23d. Date Mon			'ear
P. O.	that the de ed by the detached	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9 Unknown	death 5	1 Other (st	ecity)				_				
٦.	requires that the veen signed by th hould be detache	F.	Part II. Other significant conditions con	tributing to death but not i	esulting in the u	nderlying c	ause give	n in Part I.		23e. D	id tobac	co use contri	bute to the	he cause of de	eath?
ds,	sign d be	d by					•			1	□Yes	2 No	3 ☐ Prob	ably 4 🗆 U	nknown
Record	> 11 W	Completed								24a. W		24b M	fore auto	unes dindings a	labla
Rec	e lar has	m du								au	itopsy orforme	pr	rior to co eath?	ipsy findings a mpletion of ca	ause of
a	icien: The l certificete ha ector, page		<u> </u>							1 ☐ Ye	s 212		Yes	2 No	
Division of Vital	Physicien: this certifice ral director, p) Be	25. Was case referred to medical examiner?	ospital:			Othe			Check on			1		
ō	Physical distribution	.T	1 ☐ Yes 2 ☑ No	1 □ Inpatient 2	☐ ER/Outpatier 28b. Time o		JA	4 🗆 140				injury occurre) Hospi	ce
O	ding h. Afte fune	tlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	м	8c. Injury Work	t? Yes 2∐t				,,	-		
ISI	Attending r death. sctor: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - Al	home, farm, str					28f. Location	n (Stree	et and Numbe	r or Rura	al Route Numb	ber.
Š	efter efter Dire d in b	Certification:	4 Homicide	building, etc. (Spe	icity)					City or	Town, S	State)			
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1⊠ Certifying Phys	sician: To the best of my k	nowledge, deat	h occurred	at the tim	e, date and	d place, a	and due to t	he caus	se(s) and man	ner as s	tated.	
	ne Hc ne Fu ne Fu	edical	(Check only 2 Medical Examinate)	ner: On the basis of examinand manner stated.	ination and/or in	vestigation	, in my op	oinion, deat	th occurre	ed at the tim	e, date	and place, a	nd due to	the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and Itle of certifier			290	c. License	number			29d.	Date signed	(Month,	Day, Year)	
		. 8) / RV				D 3.	5635			Jı	ine 13,	, 200	06	
	4		30. Name and address of person who co	mpleted cause of death (I	tem 23a) (Type,	Print)					1	-			
	1		Joseph Kaplan, M.D	. 6601 Munca	ster Mi	11 Ro	oad,	Rocky	/ille	, MD	208	50			
	Sta		31. Date filed (Month, Day, Year) JUN 15 20	32. Pigistrar's Sig	nature	1 4									
	Registr	ar	2014 T 9 50	106 Bon	A A	real									

			Please 1	Type or Print in Bla						jible.	
			For State Registrar	State of Maryland		ficate of			Reg. No.	105	20522
	Physici /Medic		1. Decedent's Name (First, Middle, Last Robert Dona					2. Date of De Month	Day	2006	3. Time of Death
j.	Examir		4a. Facility Name (If not institution, give			b. City, Town,	or Location of Death	1		ty of Death $A L B$	01
40.	Funeral		THE MEMORI. 5. Social Security Number 6. Se	x 7. Age (In yrs. las	t birthday)	f Under 1 Year		8. Date of Bir	th	9. Birthp	lace (State or Foreign
	Director		200=10=0203	X M 2□ F 86	Yrs.	Months Days	Hours Min.	9 ^{Month} 4 ^{Pa}	21919	Lemo	Dyne, Pa.
	Maryland -f ehow	tor	Usuel Residence of Decedent 10a. State Md 10b. County Talbot		Town or Locat					1	0d. Inside City Limits 1 ∰es 2 ☐ No
	h with the	ai Director	10e. Street and Number 407 Water St.	P.O. Box 309		10f. Zip Code 21663			10g. Citizen o	f What Cour SA	ntry?
36	72 hours after death with the Maryland 'natural', or Iteme 23s or 28e-f ehow digs! Exaid ar must be inclified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces?	lf Y	s Decedent of es, specify Cut Yes 2 No	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Bt	ace - Americ ack, White, ify: Whi	etc.
2-00	72 hours "natural", idical Exe	sted	15. Decedent's Ed (Specify only highest grad		(Give kin	nt's Usual Occu	during most of wor	rking	16b. Kind of	Business/In	dustry
21215-0036	filed within J Hygiene. Ither then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retire	gineer	· ·	Cons	truct	cion
Maryland 2		To Be Co	12 Years 17. Father's Name (First, Middle, Last) LeRoy Nailor	1				me (First, Middle h Deito		ame)	-
aryl	2 should be and Mental and Mental is marked o	F	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing	Address (Stree	t and Number or Ru	ural Route Numb	er, City or Tow	n, State, Zip	^{Code)} 21663
_	s 1 and 2 if Health Item 27 t		Joann N. Nailo		407 Wa		t. P.O.	Box 30	9,St.		aels, Md.
nore	nt of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State Cap	i to 1	cremat	ory 6-1		Dover	, De	
Baltimore,	permit. Pages Department of I Important: If Ite eny injury or of	-	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen:		22. N	Name and Addr	ess of Facility	C+ Mia	ahaala	ьм	21662
ä	Depar Depar Impor eny ir		R. Curre	a Hueler	1 R	Carr	ox 518,	ley Fur	neral	Home,	PC PC
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused the death. one cause on each line.	Po not enter	the mode of dy	ing, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	nce of):						
	Examiner		Sequentially list conditions,	Thoraco	obdo	minal	aorti	c ane	urysm	dise	ction
	be sit	xamlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ince of):				1		
	executed and al-transit	Ехап	that initiated events resulting in death) Last	c. Due to (or as a conseque	ince of);						
68760,	te be (ysicient he buri		· ·	d							
Вох	The law requires that the death certificate be exite has been signed by the attending physicien bage 2 should be detached for use as the burial	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	leath 3□E	ctopic pregnan	су			Date of deliver	ery Day Year
P.O.	at the I by the etache	Phys	9 Unknown	9□ Unknown	da a ta ab a con d		over in Deat I	23e Did	lohacco usa co	ontribute to t	he cause of death?
ds,	signed	1 by	Part It. Other significant conditions of	rtery diseas		enying cause g	iven in Part I.		Yes 2□No		pably 4 Unknown
cor	w requir been si should	letec						24a. Was	an 24t	o. Were auto	ppsy findings available
Re	The lar te has age 2	ошр						auto perfe	psy ormed? 2XNo	prior to co death? 1 \(\text{Yes}	mpletion of cause of 2 No
ital	cien: ertifica octor, p	Bec	25. Was case referred to medical examiner?					ath (Check only			
of V	Physicien: this certific ral director,	မ	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☑ Inpatient 2 ☐ E	R/Outpatient 28b. Time of	3 UUA		Home 5 ☐ Res	idence 6 C		(y)
on	nding ith. : After e funei	tlon	1 Matural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. lnj W M 1[ork? ⊒Yes 2⊡No		,		
Division of Vital Records,	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stree	et, factory, office	Э		(Street and Num wn, State)	mber or Rur	al Route Number.
	Hospit 24 hours Funere letely fille	edical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my know iner: On the basis of examination and manner stated.	ledge, death on and/or inve	occurred at the estigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time	cause(s) and date and plac	manner as s e, and due t	stated. o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	Horou Lacira -	din		nse number 2 55 484		29d. Date sig		Day, Year) -2006
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State

DHMH 17 Rev 1/2001

Horou Laura Jin, MD 219 S. Washington St., Easton, Md. 21601
31. Date filed (Month, Pay Year) 32. Registrar's Signature Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year Month **Physician** JOHN HOWARD NEWCOMER MAY 2030 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner TALBOT HOS PITAL EASTON MEMORIAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) MAY 15 1916 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months MARYLAND 203-03-1150 90 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-1 show any injury or other traumatic event. The Madical Examiner must be natified at once. Yes 2 No TALBOT BOZMAN MD Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USÅ 7722 QUAKER NECK ROAD 21612 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐Yes 2 X No Yes, Give 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2X No Specify: 3 ₩Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) FREIGHT AIRLINE PILOT 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CORA BROWN KELLER J. NEWCOMER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PO BOX 96, WYCOMBE, PA 18980 JOANNE N. BROWN/DAUGHTER 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State CHESAPEAKE CREMATION CTR 6/2/2006 STEVENSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA MERCEROF 200 S. HARRISON ST EASTON, MD 21601 JOHN R. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypernatiemia Days **Physician** disease or condition resulting in death) (or as a consequence of): /Medical Examiner Delinum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine years certificate be executed burial-transit Dementa and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ۵ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Quriknown as been s Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 24a. Was an certificate has autopsy 2 500 1 Yes Division of Vital Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 DOA 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No this To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral funeral Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? Injury 1 Matural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cai (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number anathan 0057749 JUNE 1 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAKSHMI VAIDYANATHAN M.D. 219 S. WASHINGTON ST., EASTON, MD 21601 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 2 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JUNE **Physician** MAXIMO CONCEPCION CID ORTIZ 1 2006 2:52A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** NATIONAL INSTITUTES OF HEALTH MONTGOMERY BETHESDA 9. Birthplace (State or Foreign Country) OMINICAN REPUBLIC 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□F NONE 12 44 08 Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f ehow r than "naturel", or items 23a or 28a-f ehov The Wedical Examinar must be notified at 1 Yes 2 No DR SANTIAGO Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number CALLE PROYECTO #9 LOS COLEGIOS NONE DOMINICAN REPUBLIC Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Never Married 2 Married or ! DOMINICAN Baltimore, Maryland 21215-0036 1X Yes 2 No Specify. Specify: HISPANIC ģ REPUBLIC 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If Item 27 ie marked other than "na any injury or other treumatic avent, It a Medis 2006. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12TH. SALESPERSON PRIVATE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SERGIO VICTOR INOCENCIA OFTIZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) THERESA RAIMUND/FRIEND 1130 POWLSTON RD, GREAT FALLS, VA. 22066 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SANTIAGO, DR. BLANDINO FUNERAL HM. 06-14-06 *4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARSHALL'S FUNERAL HOME 21. Signature of Funeral Service Licensee 4217 9TH. ST. N.W. WASHINGTON, D.C. 20011 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STROKE Physician WITH CEREBRAL EDEMA DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** SYSTEM INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit The law requires that the death certificate be executed ANEMIA and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Dav for 4 Pregnant at time of death 5 Other (specify) JYes 2 □ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2X No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 Yes 2 € No 1X Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 1 XInpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred : After t Attending 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 2 Accident filled in by the 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 within 24 hours a To the Funeral I Hospitel 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier anles 041838 JUNE 9, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACQUELINE JANKA, MD 10 CENTER DRIVE, BETHESDA, MD. 20892 2. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JUN 1 3 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 10, 2006 Vernon Porter June 6:27p /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) North Carolina 8. Date of Birth (Month, Day, Year 8/21/1945 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1(XM 2□ F Yrs. 60 Director 240-72-4841 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County worle i Hygiene. other then "natural", or Items 23a or 28e-f ehov vent, the Medical Exactlise must be notified at 1√ Yes 2 No Director Camp Springs Maryland Prince George 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20746 United States 5608 Gloria Drive death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homeland Security Clerk Government 12 +1permit. Pages 1 and 2 should be file Department of Heath and Mental Hy important: if item 27 1e marked othe eny injury or other traumatic event, 9068. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brucie Vaughan William Henry Porter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) / Wife 5608 Gloria Drive Camp Springs, Md. 20746 Alee Porter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State 6/19/2006 Cheltenham, Maryland Maryland Veteran Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pope Funeral Homes, P. A. 5538 Marlboro Pike Forestville, Md. 20747 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -UNa Physician /Medical Doe to (or as a consequence of) Examiner uear 0 won Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Embolus 'umonam 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should by Be Completed menmoma 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed2 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1. Inpatient 2 ☐ ER/Outpatient Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 1 Natural s effer dea... rel Director: Aftr 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) title of pertition 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ugston 11701 ANDLINE CAINE 31. Date filed (Month, Day, Year) 2. Registrar's Signature. State JUN 1 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 116 20526 For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last 2. Date of Death 3. Time of Death Month Year **Physician** 10:20 P.M 2006 EARL HULL PETERSON JUNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner OUEEN ANNE'S 208 CHENOWETH DRIVE STEVENSVILLE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Director 83 09/03/1922 IL 353-16-0805 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 1 □ Yes 2 No Director OUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 208 CHENOWETH DRIVE 21666 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT 2 OCULAR PROSTHETIST 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be GEORGE PETERSON MABEL HULL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 CHENOWETH DRIVE, STEVENSVILLE, MD 21666 SHIRLEY ANN PETERSON / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) **EVERGREEN CEMETERY** 06/17/2006 MORRIS, IL 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Adenocarcinoma Immediate Cause (Final UNKNOWN months disease or condition resulting in death) Due to (or as a consequence of): Peritoneal meta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

with the Maryland "natural", or Itams 23a or 28a-f show solical Examiner must be notified at Pages 1 and 2 should be filed within 72 hours after death reneal of Health and Mental Hygiene.
ant: If itam 27 is marked other than "ratural", or Itams 23, ant: If itam 27 is marked other than "ratural", or other traumatic event, Ital Medical Eventual. Baltimore, Maryland 21215-0036 permit. Pages Department of Important: If it any injury or o **Physician**

/Medical Examiner

burial-transit physician the the attending signed by has

After Diractor:

Division of Vital Records, P.O. Box 68760

The law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours a

State Registrar DHMH 17 Rev 1/2001

JUN 1 3 2000

determined

4 Homicide

29b. Signature and title of certifier

Daniel Day Konick 31. Date filed (Month, Day, Year)

29a Certifier

Medicai

130 Love Point Road 32 Registrar's Signature

2000

30. Name and ordress of son o completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

June 12, 2006

Juite 107 Skrensville MP. 21666

ORIGINAL

06-04192

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State of Maryland / Department of Health and Mental Hygiene

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Bernard S Plumr		St - For State	ate of Maryla		artment of rtificate of		nd Men	tal Hygiene	2	006 2052
Obvoisia		Registrar 1. Decedent's Name (First, Middl	le.Last)		runcate or	Death	_	2. Date of Dea	Reg. N o. ath	3. Time of Death
Physicia Medical Examir	11//	Bernard	Stanle	v Pliii	mmer,J	r		Month June 17,	Day Year	
g.u.		4a. Facility Name (if not institution	n, give street and nu	umber)	1	4b. City, Town,	or Location o		4c. County o	
		402 Truitt Street				Salisbury			Wicomic	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y	ear If Unde ays Hours			9 Birthplace (State or Foreign
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any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locat	ion				10d. Inside City Limits
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arylar	Director	10e. Street and Number				10f. Zip Code	•		10g. Citizen of Wha	at Country?
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path with the Maryland items 23a or 28a-f show ust be notified at once.	Funeral	11. Marital Status		cedent Ever in U				in? (Specify Yes or No Puerto Rican, etc.)	o- 14. Race - White	- American Indian, Black,
r deatl	ᇤ	1 Never Married 2 M	1 Yes	2 X No	[, r donte rnedni, etc.)		Black
rs afte ural", miner	<u>a</u>	Widowed 4 Div 15 Decedent's Education (Spe	vorced If Yes, Give Yea or Dates:			Yes 2 X		kind of work done	Specify:	
2 hou "nati	Completed	Elementary/Secondary (0-12)				ost of working				miodo modelly
036 tthin 7 ne r than Tedica	n per	12th			Supe	rvisor	-		City o	of Salisbury
21215-0036 uld be filed within 7 Mental Hygiene marked other than		17. Father's Name (First, Middle	•				18.Mother	s Name (First, Middle,	Maiden Surname)	
121 d be f lental arkec	o Be	Bernard S	Stanley	Plumm	er, Sr.	Addross (C)	Sec	donia C	arr	01-1- 71- 0-1-)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ř	Kellee Plum						Salisbu		
e, M and 2 fealth item 2 traur	-	20a. Method of Disposition		20b.	Place of Dispos	ition (Name of		Date		City or Town, State
Baltimore, permit. Pages I an Department of Hee Important: If ten njury or other tr		1 X Burial 2 Cremation		rom State	crematory or oth wling		Ceme.	6/24/06	Prince	ss Anne, Md.
ultin nit. P artme sortan		4 Donation 5 Other S 21 Signature of Funeral Service	Licensee		_				<u>l</u> mith Fu	neral Home
Dep Dep III		Priscella	Kny	nds	9	17 W.	Isabe	ella st.	Salisbu	ry, Md. 21804
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that c on each line.	caused the death	n. Do not enter t	he mode of dyir	ng, such as c	ardiac or respiratory ar	rest, shock, or hea	rt Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease	a. Atheroso			cular dis	ease			Death
		or condition resulting in death)	Due to (or as a	a consequence of	of):					
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uted id ansit	Ë	events resulting in death) Last	d.	a consequence (01).					
O, e be executed ysician and burial - transit	edical Examiner	X UNPENDED	X AMENDED	item#1,2	23a,27,pe	mE,g857,	7/17/06	TT		
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi		IF FEMALE.		outcome of preg	gnancy				23d. Date of o	delivery
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/M	23b. Was decedent pregnant in to past 12 months?	LIVE	birth nant at time of d	ooth		3 Ectopic	pregnancy	Month	Day Year
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Division of Vital Records, tal or Attending Physician: The law require rs after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	Tof	1 ✓ Yes 2 No		Inpatient 2	ER/Outpatient		Other ₄	Nursing Home 5	Residence 6	3
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Hospi 4 hour Funer ely fill		4 Homicide 29a. Certifier Certifying P	hysician: To the be	est of my knowled	dge, death occur	rred at the time	, date and pla	ace, and due to the cau	ise(s) and manner :	as started
To the l within 2 To the l	dical			of examination				curred at the time, date		
E 18 E 8	Medi	29b. Signature and title of certifi				29c Lice	ense number		29d. Date signe	d (Month, Day. Year)
		Mayone	me Kr	ll		0.	C.M.E.		June 18, 20	06
		30. Name and address of person				0	D = 140	MD 04004	•	
		Margarita Korell MD.	Assistant Me	dical Exami		enn Street,	paitimore	e, MD 21201		
St Regis	tate trar	31. Date filed (Month, Day, Year)		gistial s digital	H. Son	nde				

		State of Maryland / Department of Hea Certificate of De		Reg. No.	06 20528
	Physician	1. Decedent's Name (First, Middle, Last) Catherine Pyne	2. Dete of Month June	of Death Dey	Yeer 3. Time of Death 2:00 P.M.
	/Medical Examiner	4e Facility Neme (If not institution, give street end number) 4b. Ci	ity, Town, or Location of C Cmmitsburg	Deeth 4c. County	
	Funeral Director	5. Sociel Security Number 6. Sex 1 Months Deys House 220-56-3636	Under 24 Hrs. 8. Dete o	Birth 27, 1921	9. Birthplace (State or Foreign Country) Pennsylvania
,	show sdet	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☑ Yes 2 □ No
	with the Ma a or 28a-f s Les notified Director	MD Frederick Emmitsburg 10e. Street end Number 10f. Zip Code		10g. Citizen of	
36	d 2 should be filed within 72 hours efter death with the Maryland th and Mental Hygiene. 7 Is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examinar must be notified at To Be Completed by Funeral Director	335 South Seton Avenue 21727 11. Marital Status 1☑ Never Married 2□ Married 3□ Widowed 4□ Divorced 218 Avenue 21727 12. Was Decedent Ever in U.S. Armed Forces? 1□ Yes 2☑ No If Yes, specify Cuban, Month of Yes, Give Yeer or Dates:	nic Origin? (Specify Yes of lexican, Puerto Rican, etc pecify:	U.S.A or No-) 14. Rac Blac Specify	ca - American Indian, ck, White, etc.
21215-0036	be filed within 72 hours et lei Hygiene. d other than "natural", o event, the Medical Exar Be Completed by	15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) College 5+ Teacher	g most of working	Religio	usiness/Industry us Community ame de Namur
Maryland 2121	Mentel Hygi mrked other atic event, I	17. Fether's Neme (First, Middle, Last) 18.	Mother's Name <i>(First, Mi</i> Elizabeth Pe	ddle, Maiden Suman	
	and 2 should latter than the marker traumetic or traumetic	19a. Informant's Name/Relationship (Type, Print) Sister Camilla Harant 333 S. Seton Av.			State, Zip Code) 21727
Baltimore,	permit. Peges 1 end Depertment of Health Important: If Item 27 any injury or other ti ang.e.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) SISTERS OF NOTRE DAN	Date ME 6/28/2006		TER, MD.
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rds, P	Attending Physician: The lew requires that the deeth certific death. ector: After this certificate has been signed by the ettending by the funerel director, page 2 should be deteched for use etification: To Be Completed by Physician/M	Constitution Parlar	24a.\	Wes en eutopsy performed?	24b. Were autopsy findings available prior to
Reco	The lew re ste hes be pege 2 sho			I∐Yes 2∏ No	completion of cause of death?
Vita	clan: ector, Be C	examiner?	. Place of Deeth (Check o		1
ō	arthis cerel director	27. Menner of Deeth 28e. Date of Injury 28b. Time of 28c. Injury at	Nursing Home 5 F	Residence 6 Oth tibe how injury occur	
Division of Vital Records,		1 □ Naturel 5 □ Pending investigation 3 □ Suicide 4 □ Homicide	28f. Location	on (Street and Numb Town, Stete)	per or Rural Route Number,
	To the Hospital or within 24 hours aft. To the Funeral Dir completely filled in Medical Ceri	29a. Certifier (Check only one) 1⊠ Certifying Physician: To the best of my knowledge, death occurred at the time, de 2□ Medical Examiner: On the bests of examination end/or investigation, in my opinion and manner stated.			
	within To the comp	29b. Signature end title of cartifier 29c. License nun	mber 2440 34	29d. Date signe	d (Month, Dey, Year)
	2	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)	121-1 0 F	23 Wes	TWAINS!
	State	31. Dete filed (Month, Dey, Year) 32 Registrer's Signature	- Curu	12500	2 mg ase

DHMH 16 Rev 6/95

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 🦩 📳 🦰 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** CHRISTINE PAULISHAK JUNE 12:27 A 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21033 GEORGIA AVENUE BROOKEVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 1 F Yrs 150 32 8907 64 23,1941 Director NEW JÉRSEY Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f ehow the Madical Examinar must be notified at **BROOKEVILLE MONTGOMERY** 1 ☐ Yes 2 No MD. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21033 GEORGIA AVENUE 20833 UNITED STATES filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier important: if I tem 27 ie marked other It eny injury geather traumatic event, Ita once. 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EDWIN HOTTINGER ELIZABETH PARKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN G. PAULISHAK, HUSBAND 21033 GEORGIA AVENUE, BROOKEVILLE, MD. 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Metropolitan Crematory 6/12/06 ALEXANDRIA, VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MURTEL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Es op has CANCER norths resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete hes t lirector, page 2 s autopsy performed? 1 Yes 2 No 1 ☐ Yes 28 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Wedical 24 within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) ٥ Klanus D39190 IUNE 12, 2006 M 10 30. Name and address of person who complete ause of death (Item 23a) (Type, Print) GARRETT REILLY, M.D. 3418 OLANDWOOD CT., #111, OLNEY, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 14 2006 Registrar

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Maryla			it of He e of D		nd Me		iene •g. No.	200	0 4	(0000		
	Dhysisi		1. Decedent's Name (First, Middle, Last)				2	Date of Deat	Death 3. Tir Day Year			ime of Death				
	Physici /Medic		Eve Marie	Pecor	raro)une	11,	2006	22	.55 M					
	Examin Funeral Director	er	4a. Facility Name (If not institution, give st The John Hopk 5. Social Security Number 6. Sex n/a	5 Haspita	i. last birthday) Yrs.	4b. City, 104 If Unde Months	Hime	ocation of I	4 Hrs. 8	. Date of Birth (Month, Day, 5/23/20	Year)	0		State or Foreign		
	Q		Usual Residence of Decedent	140-0	Vis. Town and					<i>5/ 25/ 2</i> (,,,,		-			
	anylar ehow	2	10a. State 10b. County		city, Town or Lo	ocation								ide City Limits Yes 3/1 No		
	the M	ecto	Maryland Wicomico 10e. Street and Number	F	lebron	10f 7ii	Code			1	Oa Citi	zen of What C		7.		
	with Ba or	<u></u>	26498 Meadowland L	ane			1830				US					
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23s or 28s-f ehow event, the Medical Examiner must be notilled at	by Funeral Director	11. Marital Status 1 🔀 Never Married 2 🗆 Married 3 🗆 Widowed 4 🗀 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Dece If Yes, spe	cify Cuban	panic Origir , Mexican, I	n? (Speci Puerto Ri	fy Yes or No- can, etc.)	-	14. Race - Am Black, Wh				
20	72 ho	Completed	15. Decedent's Educi (Specify only highest grade	ation completed)	16a. Dece	dent's Usu	al Occupat	ion iring most o	of working		16b. Ki	nd of Busines:	s/Industry			
2	within ene. then	mpie	Elementary/Secondary (0·12)	College (1-4or 5+)	life.	DO NOT u	se retired)									
2	filed w Hygie other ti		n/a 17. Father's Name (First, Middle, Last)	n/a	n/a	a	1	18. Mother's	s Name (First, Middle, M	Maiden	n/a Sumama)				
and	Jental Mental Me	o Be	Christian James Pe	coraro								oamamo)				
Maryland	s 1 and 2 should if Health and Men item 27 is marke other traumatic	Ě	Christian James Pecoraro 19a. Informant's Name/Relationship (Type, Print) Christian pecoraro/father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 26498 Meadowland Lane, Hebron, MD 2													
ľe,	item item		20a. Method of Disposition	20b.	Place of Dispo	osition (Na	me of other place)	Dat	e	20c. Lo	cation - City o	r Town, St	ate		
E	Pages nent of ant: If it ary or o		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State Sp	cemetery cree pringhi Sardens	ll Me	mory	6	/14/	06	H	lebron,	MD			
Baltimore,	permit. Pages Depertment of Important: If it any injury or once.		21. Signature of Funeral Service Licensed		22. Name and Address of Facility Holloway Funera 501 Snow Hill Ro						al Home Professional Associati J., Salisbury, MD 21804					
	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final											Appro	oximate ral Between t and Death		
7	/Medical		disease or condition resulting in death)	Due to (or as a conse	equence of):	3			,				50	1445		
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oʻ	cate be executed physicien and the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (G as a conse	5	1712))	AN	CITUT	ric		17	days		
8760,	cate be physici the bu	dical	d.	EXTrem	ie Pv	en	naT	uri	ry				19	aays		
P.O. Box 6	death certifi e ettending id for use es	Physician/Me									23d. Date of de Month	elivery Day	Year			
	89 PB	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use 1 Yes 2 X											se of death?		
Division of Vital Records,	e law hes b	Completed	Patent Duct	us Arte	rios	45	Markething shortings to your 'y		_	24a. Was al autops perform	V	prior to death?	completio	dings available of cause of		
/ita	iclan: Th certificete ector, pag	Be	25. Was case referred to medical examiner?						of Death (Check only on						
ž	S S	၉	1 ☐ Yes 2 💢 No		☐ ER/Outpatier			4 C IVUIS	sing Home	5 🗆 Reside	nce (5 ☐ Other (Sp	ecify)			
ů.	ing P	<u></u>	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury a Work?			d. Describe ho	w injur	y occurred				
Division	or Attending efter death. Director: After in by the fune	Certification:	2 \bigcap \text{Accident} & investigation \\ 3 \bigcap \text{Suicide} & 6 \bigcap \text{Could not be} \\ 4 \bigcap \text{Homicide} & determined	28e. Place of Injury - At building, etc. (Spec								(Street and Number or Rural Route Number, own, State)				
	Tothe Hospital or Attending Phymin 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	edical Co	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	cian: To the best of my ki er: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred	at the time	, date and nion, death	place, and occurred	d due to the ca at the time, da	ause(s) ate and	and manner a place, and du	is stated.	ause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29	c. License	number		2	9d. Dat	e signed (Mor	ith, Day, Y	ear)		
	(2)		19 Chinton	Pa MD		ì	000	600	091) [:	Tu	ne 12	1.20	200		
-	1 De		30. Name and address of person who con	pleted cause of death (Ite	эт 23а) (Туре,	Print)	91=-	-	121				,			
	10		Elizabeth Cris	THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER.	ON.W	olfe	St.	Bal	tim	cre,	MI	D 319	F8			
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 4 20	32. Registrar's Sign	nature	bank.	,			,						

06-04208 Nevin Potter

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Cert	ificate of De	ath	Rec	g. No.	00 400
Physici	an/	Decedent's Name (First, Middle,L.		0		2. Date of Death Month	Day Year	3. Time of Death
ledical Exami	ner	Nevin	Keith		er	June 17, 20	006	1830 hrs
		4a. Facility Name (if not institution, g Easton Memorial Hospita	· ·		y, Town, or Location of D ston	eath	4c. County of Death	1
Funeral			Sex 7. Age (In yrs. las	st birthday) If L	Inder 1 Year If Under 2	4Hrs. 8. Date of Birth		thplace (State or
Director	1	212 21 31/3/1	ØM 2□F 3.3	Yrs. Mo	nths Days Hours	Min.	Forei	gn Juntry) , /
		Usual Residence of Decedent	<u> </u>	0 110.		Oct.	/ 1113	Maryland
, апу		10a. State 10b. County	10c. City, 7	Town or Location				10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ē	MD Queen	Anne's G	rason	Ville			1 Yes 2 No
Maryl 28a-1 d at 9	Director	10e. Street and Number		10f.	Zip Code	10	g. Citizen of What Cou	ntry?
th the 23a or notifie		402-GIL	bs Road		21638		USA	
21215-0036 ald be filed within 72 hours after death with the Maryland Manal Hygiens and when Hygiens as or 28a-f she marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U.S Armed Forces?	3. 13. Was Dec If Yes, sp	edent of Hispanic Origin? ecify Cuban, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
rer de		3 Widowed 4 Divorc	1 Yes 2 No ed If Yes, Give Year	1 Yes	2 No specify:		Specify: B	ack
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5 72 hc ru "ns cal Ex	lete	Elementary/Secondary (0-12)	College (1-4 or 5+)	0	working life. DO NOT use	e retired)	Δ	
5-0036 led within 7 Hygiene. other than	Completed	10		Car	Penter		Constr	uction
15- filed il Hyg ed oth t, the	ပိ	17. Father's Name (First, Middle, La	Dal		+ 1	Name (First, Middle, M	laiden Surname)	
2121 ould be fi Mental marked	o Be	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Addr	ess (Street and Number	r or Rural Route Numb	ber, City or Town, State	. Zip Code)
MD 12 sho th and n 27 is	-	Deborah:	Jackson		3 4	, /	Delaware	
2 7 7 7		20a. Method of Disposition	20b. Pl	lace of Disposition (rematory or other pla	Name of cemetery,	Date	20c. Location - City or	
Baltimore, permit. Pages I ar Department of Hes Important: If ite		1 Burial 2 Cremation 3	Removal from State	van's Chur	ch Cemetery	6/24/06	Grasowil	Le MD
Baltime permit. Pag Department Important: injury or ot		21. Signature of Funeral Service Lic	ensee	22. Name :	and Address of Facility	1 Home P	A.	10) 111 01
		Janelle	C. Henry	5/0	and Address of Facility RY Funera Washing to	N St. Ca	ubridge,	MD, 21613
Physician /Medical		23a. Part K Enter the disease, or con failure. List only one cause on	each line.		de of dying, such as card	iac or respiratory arre	st, shock, or heart/	Approximate Interval Between Onset and
caminer		Immediate Cause (Final disease or condition resulting in death)	a. Cocaine intoxicati Due to (or as a consequence of)					Death
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68760 ertificate b iding physice as the bu	2	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnant		ath 3 Ectopic pr	regnancy	23d. Date of deliver Month	
Sox 687 leath certific e attending	Physician	past 12 months?	4 Pregnant at time of	2 Fetal de		egnancy	Month	Day Year
Box e death c the atten ed for us	hys	1 Yes 2 No 9 Unkno	a Oliviowii					
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of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should l	입	1 Yes 2 No 27. Manner of Death	i inpatient 2 V	28b. Time of Injury	DOA Other N		Residence 6 Othe	r:
ਵ ਚੋਂ ੂੰ `ਵੀ	cation	1 Natural 5 Pending	(Month, Day, Year)	Fnd 6:30 pm	1 Yes 2 No	Subject in	igested cocair	ne prior to
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Divisospital or Andreas after Incentional Directors of Filled in By Filled in By	Certifi	3 Suicide 6 ♣ Could n 4 Homicide				or Town, Str unk	ate)	
E Fu			ician: To the best of my knowledge					
To the He within 24 To the Fu	ledical		ner:On the basis of examination an and manner stated.	id/or investigation, ir		red at the time, date a		
	Σ	29b. Signature and title of certifier	•		29c. License number		29d. Date signed (Mo	nth, Day, Year)
		Muld			O.C.M.E.		June 18, 2006	
-		30. Name and address of person when Ana Rubio MD. Assist			t, Baltimore, MD 21	1201		
S	tate		2006 32. Raistrar's Signatur		-,			
Regis		JUN 2 2	Claur 1	OF ADDRESS				

DHMH 17 Rev 1/2001

State

Registrar

31 Date filed (Month, Day, Year)

JUN 1 6 2006

32/Registrar's Signature

		•	For State Registrer	State of Ma	arylan		rtment tificate			and M	ental H	ygie Reg.	- J. U U	5	20533
	Physici	2 P	1. Decedent's Name (First, Middle, Las	Ť							2. Date of I		Day Y	eer	3. Time of Death
	Physici /Medic		Emil Stanle	-	er						06 ^{Month}	20	^{Day} 2006		6:40p M
	Examin	1901 188	4a. Facility Name (If not institution, give						Location of				4c. County of		
	.81	12.	Long View Nursing Home Manchester 5 Social Security Number 6. Sex 7. Age /In vrs. /ast birthday) If Under 1 Year If Under 24 Hrs. 8 Date									lieth	Carı		
	Funeral	5. Social Security Number 197–12–6757 6. Sex 1 1 1 1 2 F 81 Yrs. 81 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1									8. Date of 8 (Month, 107-05	Day Ye	ar)	Cou	place (State or Foreign htry) PA
sel-c	- Director		Usual Residence of Decedent		01						07-03	,- <u>1</u> 5	24		FA
	ahow		10a. State 10b. County	2		y, Town or Lo									0d. Inside City Limits
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	다 다 9r 28	Sire	10e. Street and Number				10f. Zip					10g.	Citizen of Wh	at Cou	ntry?
	23a	Funeral Director	6017 Vandyke St					191					USA		
	er de	nue	11. Marital Status	12. Was Decedent Armed Forces?		S. 13. \	Was Decede f Yes, spec	ent of Hi ify Cubai	spanic Ori n, Mexican	gin? (Spe i, Puerto	ecify Yes or I Rican, etc.)	No-	14. Race - Black,		
36	rs aft	by F	1 Never Married 2 Married 3 ∑Widowed 4 Divorced	1 X Yes 2 ☐ I If Yes, Give Year or Dates:	№ 194 194	3-	1 ☐ Yes 2	₩ No	Specify:				Specify:	Whi	te
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ahow ha Mudical Exercition mast ke notified at	ed	15. Decedent's Ed	ducation	134	16a. Deced	lent's Usua	1 Occupa	ation			16b	. Kind of Busi	ness/In	dustry
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yla	2 should be t and Mental F is marked of reumatic aver	ပ္	Joseph Prajzr								a Jas				
Maryland	2 sh and ie m		19a. Informant's Name/Relationship (O		-						ty or Town, St		
	1 and 1 Health tem 27		Joseph J. Prajzne	er, Sr ;		1ace of Dispo			is Lai		dampst		, MD 21 Location - Ci		
Baltimore,	Pages 1 nent of h int: if ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	C	em <i>etery, crer</i>	natory or ot	her place							
tim	permit. Pages 1 and 2 should Depertment of Health and Men Important: if Item 27 is marke any injury or other treumatic angee.		4 Donation 5 Other (Specif		Ca	rroll				6-22-					MD 21074
Bal												ne Funeral Home			
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			shock, or heart failure. List only Immediate Cause (Final	one cause on each li	use on each line.									Interval Between Onset and Death	
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Вох	ettend tor us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal	I déath 3	Ectopic pre						23d. Date of Month		ery Day Year
o.	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	t tarre or di	balli SL	JOHIBI (Spe					•			
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	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely tilled in by the	Мес	29b. Signature and title of certifier	and manner of			29c.	. License	number			29d.	Date signed (Month,	Day, Year)
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/	py		30. Name and address of person who	completed cause of c	death (Item	23a) (Type	Print)		~J 7	13		4	100	1 4	21157
	10 trate	7	/ Tol 11 n	idaleton	n	0 6	28 P	10/2	Real	d	West	1	· s.ke	M	21157
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10.5	Regist		JUN 2 2	2006	we.	K. 14	mark	/							

State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ruth M. Pahl June 5:25 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Copper Ridge Sykesville Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 21, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 K F 215-14-9089 84 Maryland Director 1921 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Carroll Sykesville 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 710 Obrecht Road 21784 United States Itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 200No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status permit. Pages 1 and 2 should be tiled within 72 hours atter o Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural; or item eny injury or other traumatic event, the Medical Exercita 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: à Specify: White 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore County College (1-4or 5+) 2 years Elementary/Secondary (0-12) Cafeteria Public Schools Mana er 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Joseph Westgate Helen Baker Schaaf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wesley S. Pahl 4127 Aberdeen Lane Lake Wales, FL Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery June 23, 2006 Woodlawn, MD 21. Sign tun of Funeral Service License 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784 23. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final liseage or condition read ting in death) Dementia **Physician** 1025 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Ø No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 | Inpatient Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury To the Hospital ... within 24 hours after death.
To the Funerel Director: Alt 1 Natural 5 Pending 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00059993 June 20,2006 احروا 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SVITE 307 westminster MO 295 Stoner AR. Isnn C. Appl (MO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 2 2 2006 Registrar

			For State Registrar		State of Ma	aryland /			te of E		Mental H	ygiene Reg. No		20535		
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	Medical Catherine Charitonuk Peterson										June	13	2006	10:45 A ^M		
	Examin	er		If not institution, give						Location of Death	1		County of Deatl	1		
			5. Social Security N	Hospice H	hirthday		astor	If Under 24 Hrs.	8. Date of I		Talbot	nplace (State or Foreign				
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	Ba-1 e	Director	Maryland	Caroline		Dent	on							1 ☐ Yes 2X No		
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020	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: If them 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.	by Funerai	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed	ried 2 Married 4 □ Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:			Yes, sp		spanic Origin? (Sin, Mexican, Puert Specify:	Rican, etc.)	10-	Black, White	e, etc.		
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o uoisio	To the Hospital or Attending Physician: The law within 24 bouts else death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2		27. Manner of Death 1								28d. Describ	28d. Describe how injury occurred				
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	To th within To th compl	Me	29b. Signature and	title of certifier				29	c. License	number		29d. Da	ite signed (Month	, Day, Year)		
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			30. Name and add	ress of person who o	completed cause of de			,		•						
				Moffett, M				ent o	n, MI	21629						
Ī	Sta Registr		31. Date filed (Mor	JUN 1 6 2	32. Registra	ar's Signature	K A	part								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. TCHD/06/16/06, sbb Courtment of Health and Mental Hygiene UUU Amended,#31 per For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1305 lune 2006 DONALD H. PAINTER /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner ambridge orchester General Hospital Dorchester If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) JUN 21 1921 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1**X**M 2□ F Months Hours 84 202-07-8154 Director Usual Residence of Decedent with the Maryland 10c. City Town or Location 10d Inside City Limits 10h County 10a State Pages 1 and 2 should be filed within 72 hours after death with the Marylar nant of Health and Mental Hygiene.
ansi: If Item 27 is marked other then "natural; or Items 23e or 28e-f show up or other treumatic event, Item Medical Establing mast be notified at my or other treumatic event, Item Medical Establing 1XYes 2 □ No Director DORCHESTER CAMBRIDGE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21613 USA 520 GLENBURN AVE Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ▲ Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: Specify: WHITE 3 Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STEEL 12 0 SCRAP CUTTER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be RHODA MAY KULP 2 DONALD H. PAINTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CAROL MULLINS/FRIEND 30343 KATES POINT ROAD, TRAPPE, MD 21673 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Importent: If Ite. any injury or otl t ☐ Burial 2 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 6/15/2006 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Ostruusk. 200 S. HARRISON ST EASTON, MD 21601 1 oseph 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown à signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed' certificate 2 X No 1 ☐ Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 X No 1 Xinpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospitel or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeret [Medical VCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 29c. License number

Carly

Registrar

UR 31. Date filed (Month, Day, Year) -

300

32 gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		For State Registrar	State of Marylar		artment of H tificate of L			iene 2001 og. No.	6 20537
D		1. Decedent's Name (First, Middle, Last)					2. Date of Deat	D	3. Time of Death
Physicia /Medic	- 1	Earthalea L.	Ross				June 6,	2006	1:18 A M
Examin	er	4a. Facility Name (If not institution, give si	reet and number)		4b. City, Town, or	Location of Death		4c. County of Dea	th
		Southern Maryland 5. Social Security Number 6. Sex		land historia	Clinton If Under 1 Year	If Under 24 Hrs.	9 Date of Birth	Prince	George's
Funeral			7. Age (In yrs.	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign cuntry)
Director	}	Usual Residence of Decedent					January_	5, 1919 Ne	w Orleans, L
aryland show		10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
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r dee	Funeral	11. Marita States	Was Decedent Ever in U Armed Forces?	J.S. 13. 1	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	erican Indian. African-
s afte	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes Ž No	Specify:			merican-
tural tal		3 ☐Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Occupa	ation		16b. Kind of Business	
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and 2 alth a		Sabrina D. Hill -				eld Drive	Clinton	n, Marylan	d 20735
Of He Transfer of the roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		Place of Dispo cemetery, crer	sition (Name of natory or other place	е)	Date	20c. Location - City or	Town, State
Pag Tent ant: I		4 Denation Other (Specify)	Pr		ce Mem. P			Metairi	,
Definition of your permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other transpace.		21. Signature of Fun rals Tipe License	1	22	. Name and Addres	s of Facility Ste	wart Fu	neral Home	, Inc.
205		Jan Ju	1					ington, DC	
		23a. Part1 Enter the disease, or complice snock, or heart failure. List only on	ations that caused the dea e cause on each line.	th. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arm	est,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	Bilatural Po	umo me	c with K	uporatory to	ii line		Oriset and Death
/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	•	,			
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ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 101 00 0 00100	400100 01).					
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or A offer offer on by	art.	4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	ify)	eet, ractory, onice		City or Town		urai noute ivumber,
The spital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death. To the Funaral Director: After this certificate hes been signed by the eltending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	2	29a. Certifier A Certifying Phys	ician: To the best of my kn	owledne death	noccurred at the time	e date and place	and due to the or	ause(s) and manner a	hateta
24 hos Fun etely	edical	(Check only 2 Medical Examinone)	er: On the basis of examin and manner stated.	ation and/or in	vestigation, in my or	pinion, death occur	red at the time, da	ate and place, and du	e to the cause(s)
omply	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (Mon	th, Day, Year)
(1)		> Naha			D005	5120	1.7	une 6 200	<
CVC)		30. Name and address of person who con	npleted cause of death (Ite	m 23a) (Type,				V V (/
Jan Co		Richard Palmer in		em aven	me SE Sui	H 310 Was	· Ging hor .	DC 20032	
Sta	te	31. Date filed (Month, Day, Year)	32. Redintrar's Sign	sture			7		

			1 - For State Registrar	State of	f Marylar				ealth a Death	nd Me		giene Reg. No.	UU	5	20	530
			1. Decedent's Name (First, Middle, La	st)							2. Date of Dea	ath Day	Ve	ear :	3. Time of	Death
П	Physici /Medic		Isolyn Riley-Wr	ight							June	8,	200		6:13	Ам
	Examin		4a. Facility Name (If not institution, give		mber)				Location of			4c.	County of (Death		
		Щ	Holy Cross Hosp 5. Social Security Number 6.5		7 4 0	1-14-1-1-1	L .	llver	Spri				lontg			-
	Funeral Director			ΘX □M 2፟Ω̄F	7. Age (In yrs. 85	Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Da July 2.	Year)	9.	Country	e (State o aica	r Foreign
			Usual Residence of Decedent		0.5						oury 2	J 9 1.	/20	Jame	arca	
	how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d.	. Inside Ci	
	Ba-f	cto	Maryland Montgom	ery	Si	llver S	pring	3							1X Yes	2 🗌 No
	or 24	Director	10e. Street and Number 13942 Alderton R				10f. Zig					-	en of Wha			
	e 23e				4-45	10 40		0906		1-0 (0-	7 7		ed S			
	ler de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Fo			was Dece If Yes, spe	cify Cuba	n, Mexican,	Puerto R	cify Yes or No- lican, etc.)	. '	4. Race - A Black, V	Amencan White, etc		
336	urs af	þ	3 ∑ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	re		1 🗆 Yes	2X No	Specify:				Specify:	Blac1	k	
Š	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or Iteme 23e or 28e-f ehow event, the Medical Exart hat must be notified at	Completed	15. Decedent's E	ducation		16a. Dece				of works		16b. Kin	d of Busin	ess/Indus	stry	
21	thin 7	npie	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT u	se retired,								
21	ygien ygien ygien ygien ygien		12			Certi	fied	Nurs	ing A				vate			
D D	be fill	Be	17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden :	Sumame)			
$\frac{3}{2}$	12 should be filed wi n and Mental Hygien is marked other th iraumatic event, the	ဥ	Daniel Riley 19a. Informant's Name/Relationship (Type Print)		10h Mailir	a Address	/Street a			Mattis Route Numbe	r City or	Town Sta	to Zio Co	ada)	
<u>S</u>	d 2 s th an t7 is trau			daughte	r)						lver Sj	-		209		
ō,	Heel Heel		20a. Method of Disposition	44451100		Place of Dispo	sition (Na	me of	Noau	Da			ation - City			
e E	Pages ent of		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Siate	ck Cree				/17/	06	Wash	ingto	on. I	D.C.	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Heelth and Menta important: If item 27 is marked eny injury of other traumatic events.		21. Signature of Funeral Service Lice)						ire Fu					
ñ	20 E 2		Thomas 19	Clerk	nun						.W., Wa				012	
}	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, lany, leading to immediate cause. Enter Underlying	a. Asy Due to (stole for as a consecution of a consecution of as a consecution of a	quence of):		ie or aying	g, such as c	eardiac or	respiratory ar	rest,		In	pproximate terval Bett nset and I	ween
68760,	tificate be executed by physicien and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):										
P.O. Box	death cer e attendir ed for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 □ No 9 ☐ Unknown		irth 2 ☐ Feta ant at time of c	al death 3	Ectopic pi Other (sp					2	3d. Date of Month	delivery Da	ay Y	/ear
Division of Vital Records, P	6 50	Completed by Pi	Part II. Other significant conditions of End Stage Renal		eath but not res	sulting in the u	nderlying o	ause give	n in Part I.		23e. Did to		e contribut			
ပ္တ	¥ 0 0	piet	Seizure Disorder								24a. Was		24b. Were	e autopsy	findings a	available
Ĕ	The law ate has b page 2 sl	EO										med? 20 No	deat	h?	letion of ca	luse of
ita	hystcian: The la his certificate has I director, page 2	Be	25. Was case referred to medical examiner?						26. Place o	of Death (Check only o	-				
<u>></u>	Attending Physician: r death. sctor: After this certification in the funeral director.	2	1 ☐ Yes 2XXNo			ER/Outpatien	t 3□ D0	Othe	r: 4 🗆 Nurs	sing Hom	e 5 ☐ Resid	dence 6	□Other (5	Specify)		
Ĕ	ding P. h. After t	ou	27. Manner of Death 1X□ Natural 5 □ Pending		of Injury h, Day Year)	28b. Time of Injury		28c. Injury Work			3d. Describe h	ow injury	occurred			
Sic	tend death tor: / the t	cat	2 Accident investigatio 3 Suicide 6 Could not b		of tolure At he		М		/es 2 □ No		34 Landing (6		A 1 - 1 - 1 - 1	- /-		
<u>></u>	- 9	ertification:	4 Homicide determined	buildir	of Injury - At h ng, etc. <i>(Speci</i>	fy)	eet, ractor	у, опісе		20	3f. Location (S City or Tow	n, State)	Number o	r Hurai Hi	oute Numi	oer,
	ours ours heral filled	Medical Co	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the niner: On the ba and mann	asis of examina	owledge, death ation and/or in	occurred vestigation	at the tim	e, date and pinion, death	place, an	nd due to the d d at the time, d	cause(s) a date and p	nd manne place, and	r as state due to the	ed. e cause(s)
	To the Horwithin 24 h To the Fur	Me	29b. Signature and title of certifier	174	1 .		290	c. License	number			29d. Date	signed (M	onth, Day	v, Year)	
	,		· CXVV	11/W/	M			D0635	579			Jun	e 8,	2006		
(J		30. Name and address of person who	completed caus	e of death (Ite	m 23a) (Type,	Print)									-
_			Maria J. Tayag, N	M.D. 15	00 For	est Gle	n Ro	ad, S	Silver	Spr	ing, M	D	2091	.0		
Tr.	Sta Registr		31. Date filed (Month, Day, Year) JUN 15	2006 32. 8	gistrar's Sign	atury.	peur									

		1 - For State Registrar		Maryland / Depa	artment of H		R	Reg. No.	20509
Physic /Medi		1. Decedent's Name (First, Middle, Lilly Re	eaver				2. Date of Dea Month June 14	Day Year	3. Time of Death 6:00 a. M
Exami	-	4a. Facility Name (If not institution, g				rsville		4c. County of De	k
Funeral Director		218-30-9525	. Sex 7	Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	if Under 24 H Hours Mi	in. (Month, Day	9. B 7. Year) 9. B	irthplace (State or Foreign Country) Illinois
faryland show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Freder	ick	10c. City, Town or Lo					10d. Inside City Limits
death with the Maryland ms 23a or 28a-f show rmust be notified at	Direct	10e. Street and Number 56 W. Frederick			10f. Zip Code 2179)3	1	10g. Citizen of What C	Country?
_ <u>a</u> <u>a</u> a	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced	12. Was Decede Armed Force	s? ≦No s:	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes Æ No	ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		
VIZIS-UU36 within 72 hours af ene. than "natural", or the Medical Exam	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of w	vorking	Own home	
be filed that Hyg ad othe evant,	To Be Co	17. Father's Name (First, Middle, La John Hendrick	· ·	ZIOMCII			Name (First, Middle, a		
Mar nd 2 sh alth and 27 Is rr or traum		19a. Informant's Name/Relationship Kay Hoff - Da	o (Type, Print) ughter					r, City or Town, State,	· ·
Baltimore, r permit. Pages 1 and Department of Healti Important: If item 27 any injury or other 1		20a. Method of Disposition 1 Seburial 2 Cremation 3 4 Donation 5 Other (Special Service Lieuward)	cify)	Linganore	e Cemetery	7 6–16	5-2006 U	20c. Location - City of Inionville : Funeral Hon	, Maryland
ate be executed Thysician and	dical Examiner	25a. Part1. Enter the disease, or or shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	sed the death. Do not en				lerick, Mar	Approximate Interval Between Onset and Death
death death e atter	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3[t at time of death 5[□Ectopic pregnancy □ Other (specify)	-		23d. Date of d Month	elivery Day Year
S, L	by	Part II. Other significant condition	s contributing to death	h but not resulting in the t	inderlying cause giv	en in Part I.	23e. Did tol	_/	to the cause of death? Probably 4 □Unknown
I HeC The law ate has b page 2 st	Completed						24a. Was a autops perfor 1 □ Yes	sy prior to med? death?	autopsy findings available occumpletion of cause of as 2 No
Of VICAL F Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?	Hospital: 1 Inpa	atient 2 ER/Outpatie	nt 3 DOA Oth	er a	Death <i>(Check only on</i> Thome 5 ☐ Reside	ne) ence 6 □Other (Sp	ecify)
Unel		27. Manner of eath Natural 5 Pending investiga	tion	njury 28b. Time o Day Year) Injury	Wor	yat k? Yes 2 □ No	28d. Describe ho	ow injury occurred	
i Diffe	Certification:	3 Suicide 6 Could no 4 Homicide determin	t be ed 28e. Place of building,	Injury - At home, farm, st etc. (Specify)	reet, factory, office		28f. Location (St City or Town	treet and Number or F n, State)	Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Directory completely filled in 1	edicai	(Check only Ž Medical Ex	Physician: To the be taminer: On the basis and manner	est of my knowledge, deat s of examination and/or in stated.	vestigation, in my o	pinion, death oc	ccurred at the time, d	late and place, and du	ue to the cause(s)
To t To t	Σ	29b. Signature and title of certifier	Colonia	Attel m	29c. Licens			29d-Bate signed (Mor	
10		30. Name and address of person w	no completed cause	of death (Item 23a) (Type	Print) West	+ gth	Freet	Frederi	ck, MD)
St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 1 6	2006 32. Figure 32. Fi	strar's Signature	book				,

State of Maryland / Department of Health and Mental Hygiene / 📋 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** KHONE - MASON AMAR D9'58A M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner SHADY GROUE HOUENTUT HOCKVILLE ler 1 Year If Under 24 Hrs. MONTGOMERY If Under 1 Year 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10 M 2□F NONE Director MARYLAND Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or Itams 23a or 28e-f ahow rant, the My dical Examinar must be notified at 1 Yes 2 □ No MARYLAND MONTGOMERY ERMANTOWN, by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 13303 DHLE 20874 filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1□Yes 2No 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INFAN Department of Health and Mental Hygie Important: if Item 27 is marked other ti any Injury or other traumatic avent, III. 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MASON JR LAMAR ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOTHER 135U5

20b. Place of Disposition (Name of cemetary, crematory or other place) #E, GERMANTOWN Date 20a. Method of Disposition 20c. Location - City or Town, State 3 Removal from State 1 Burial 2 Cremation CYCLE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Farlace Service Licensee MEDICAL Approximate Interval Between Onset and Death Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner EME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 MNo 9 □ Unknown 23d. Date of delivery 3 DEctopic pregnancy signed by the atter Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 2 No cete has been signated to page 2 should to 3 Probably 4 □Unknown 1 ☐ Yes 24a. Was an autopsy performed? 1□ Yes 20 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No within 24 hours effer death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 XNatural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day 28d. Describe how injury occurred 5 Pending investigation 1 Tyes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier " 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) KENZI, 990 MEDICAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene (1995) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year BARBARA JEANETTE RENNER 14,2006 2:07 A June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 220-74-5216 62 Director Sept. 5, 1943 Maryland Usual Residence of Decedent 10a. State 10b. County Show 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Miccigal Examiner must be notified at Maryland Frederick Frederick Directo 1 TYPes 2 □ No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ត 425-A, Carrolton Drive 238 21702 United States death Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 Yes. Give 1 ☐ Yes 2 X No Specify: ģ If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of rmit. Pages 1 and 2 should be apartment of Health and Menta portant: if item 27 is marked by njury or other traumatic ev George Renner Margaret Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry C. Renner / Brother 11433 Hill Rd. Keymar , Maryland 21757 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem.Garden 06/17/2006 Frederick, Maryland permit.
Deportri
Imports
any nju 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licenses mondo 1621 Opossumtown Pike/ Frederick, MD 23a. Part I. Enter the disease, or com shock, or lear failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Immediate Gause (Final disease or condition resulting in death) Acrto Anlar Sepha Myrana an Infantion **Physician** /Medical Due to (or as a consequence of): Examiner HF Dequentially fist conuctors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit death certificate be executed Due of ras a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death Day 5 Other (specify) P.O. ate hes been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ፩ Completed 25€ 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? hes autopsy performed? res 26 No 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes To the Hospital or Attending Physician: funeral director 25. Was case referred to medical 26. Place of Death Check only one Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 25 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t 28b Time of 28c. Injury at 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/15/06 Their MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MO 217VI 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State Registrar JUN 1 6 2006

	1	For State Registrar	State of Marylar		artmen rtificate			and Me		giene Reg. No	E 0 0	Ü	20512
		Decedent's Name (First, Middle, Last)							2. Date of De	ath			3. Time of Death
Physicia /Medica		Arden Monroe R	eyno1ds						June 9	, 20	06	эаг	10:40 P M
Examine	90	4a. Facility Name (If not institution, give s	treet and number)				Location o	f Death			. County of		
		2805 Bosworth Lan 5. Social Security Number 6. Sex		for a fill of the state of the	B If Under	owie	If Under 2	24 Hec			rince		
Funeral Director		236-26-7504 ^{1X}	7. Age (In yrs. 83	Yrs.	Months	Days	Hours		8. Date of Bin (Month, Da July 4	y, Year, 192	2	WV	ace (State or Foreign try)
and and	-	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation							10	Od. Inside City Limits
nours arrer death with the manyand ural, or items 23s or 28s-f show al Examinar mast be notified at	0	MD Prince G		Bowie									Y Yes 2 No
r 28a	Director	10e. Street and Number	8	-	10f. Zip	Code				10g. Ci	tizen of Wha	it Count	try?
23a o		2805 Bosworth Lan	e			2071	.5				USA		
, a	oy rur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in L Armed Forces? 1X Yes 2 \(\) No If Yes, Give Year or Dates:		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	offy Yes or No lican, etc.)	•	14. Race - Black, ' Specify:	White, e	etc.
than natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usua kind of wor DO NOT us	rk done d se retired,	luring most)	of workin	g	Ann	ind of Busin ie Aru Educa	nde]	l Board
tic event,	o ge	17. Father's Name (First, Middle, Last) Forrest Tucker Rey	nolds						(First, Middle, rtha H				
raum		19a. Informant's Name/Relationship (Type			-				Route Numbe			te, Zip	Code)
thert	1	Nancy Reynolds/ Wi		2805 Place of Dispo	Bosw		Lane	Da BO	wie, M		20715 ocation - Cit	u or Tou	un State
7 or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ntt Cre	natory or or	ther place		5/13/			Ldorf,		wn, state
any injury or other traumatic ev		21. Signature of Funefal Service License		22	2. Name an	d Addres	s of Facility	Robe	rt E. d Bow	Evar	ıs Fun		
hysicia the but	dical Examiner	23a. Pant1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a))).	(uence of):		1 .	1 N						Interval Between Onset and Death
tached for use as	rnysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ac. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a	Il death 3	Ectopic pre						23d. Date o Month		y Day Year
p eq .	2	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to				e cause of death?
ge 2 should l	Completed								24a. Was autop		24b. Wer	e autop	sy findings available ipletion of cause of
certificate ha		25. Was case referred to medical		-			00. 51	-4 D11-11	1 Yes	2 No	10	Yes 2	2□ No
director,	o pe	examiner?	ospital: 1 Inpatient 2	ER/Outpatier	it 3 DO	A Othe	-		Check only o		6 □Other (Specific	1
		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Bc. Injury Work	at	28	3d. Describe h			Specily)	/
d in by fhe	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str (y)					3f. Location (S City or Tou	Street ar In, State	nd Number o	r Rural	Route Number,
	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knower: On the basis of examinational manner stated.	wledge, death ation and/or in	n occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, ar h occurred	nd due to the d d at the time,	date and	and manne d place, and	r as sta due to t	ited. the cause(s)
To the	ž	29b. Signature and tile of certifier	\		29c	License	number	72		29d. Da	te signed (A	fonth, D	Day, Year)
		30. Name and address of person who co	mpleted cause of death (Iter	п 23а) (Туре	(Fint)	1/2	0/	, U	2. 2	0	-12	- 4	1
	1	N. Javy Kolj 31. Date filed (Month, Day, Year)	HOOD N	115 ch.	יוען נ	1/2	159	1	312	3	いいし	. /	至0716
Stat Registra	100	.IUN 1 4 200)6	k S	and s								

		For State Registrar		Department of Health Certificate of Deat	and Mental Hygie h Reg	ne_000 2054.
Physic /Med	cal	1. Decedent's Name (First, Middle, Las <u>Charles David Ri</u>	ska	4b City Town as Location	2. Date of Death Month June 11	Day Year 3. Time of Death
Exami	ner	4a. Facility Name (If not institution, give 906 Ridge Road	street and number)	4b. City, Town, or Location Rising Sur		4c. County of Death Cecil
Funeral Director		210-00-0330	7. Age (In yrs. last b	irthday) II Under 1 Year If Und Months Days Hours	er 24 Hrs. 8. Date of Birth (Month, Day, You March 31	9. Birthplace (State or Foreign Country) 1974 Delaware
ahow	j.	Usual Residence of Decedent 10a. State 10b. County		wn or Location		10d. Inside City Limits 1 ☐ Yes 2 💆 No
or 28a-f	Director	MD Cecil 10e. Street and Number	KLSA	ing Sun 101. Zip Code	10g	Citizen of What Country?
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic avent, the Medical Examirar must be notified at	by Funeral	906 Ridge Road 11. Marital Status 1 Never Married 2 XMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ \(\frac{1}{2}\)\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	21911 13. Was Decedent of Hispanic (If Yes, specify Cuban, Mexic		USA 14. Race - American Indian, Black, White, etc. Specify: White
d within 72 hours af giene. ar than "natural", or the Medical Exami	Completed b	15. Decedent's Ed (Specify only highest gra	de completed)	a. Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired)	ost of working	b. Kind of Business/Industry
filed withi Hygiene. other ther		Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+) 4	Electronic Techn		Arcades
d 2 should be filt th and Mental Hy 27 is marked oth traumatic avent	To Be	Michael Edward 1		Jo	oyce M. Fagley	
and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (Marianna Riska/u	vife	b. Mailing Address (Street and Nurr 906 Ridge Road,	Rising Sun, MI	21911
permit. Pages 1 and Depermit. Pages 1 and Important: If Item 27 any Injury or other tronce.		20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi	Removal from State cemet	of Disposition (Name of ery, crematory or other place) Foard Funeral Ho	06-13-2006	c. Location - City or Town, State Sing Sun, Maryland
permit. Pa Depertmen Important: any Injury once.	ľ	21. Signature of Funeral Service Licer	Gordie	22. Name and Address of Fact		uneral Home. P.A.
Finy Sician (Medical Medical M		23a. Part.* Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Maligh and Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence	Melanoma e ot):	as cardiac or respiratory arrest	Approximate Interval Between Onset and Death M
The law requires that the death certificate be ex sie hes been signed by the ettending physicien i page 2 should be detached for use as the burial	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
quires that in signed by		Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying cause given in Pai		co use contribute to the cause of death?
The law requires to the law requires to the law been signed, page 2 should be contact.	Completed by				24a. Was an autopsy performe	24b. Were autopsy lindings available prior to completion of cause of death? No 1 Yes 2 No
rsician s certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Other	ace of Death Check only one) Nursing Home 5 Residence	e 6 ☐Other (Specify)
To the Hospital or Attanding Physician: The law within 24 hours elter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: 7	27. Manner of Death 1 Anatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	(Month, Day Yeer)	Time of Injury at Work? M 28c. Injury at Work? 1 Yes 2 farm, street, factory, office		et and Number or Rural Route Number,
na Hoapital 124 hours e na Funaral I	Medical Ce	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exer	ysician: To the best of my knowledgeniner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and/or investigation, in my opinion, d	and place, and due to the caus leath occurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier H. Forward	, M	29c. License numbe	111	Date signed (Month, Dey, Year) LOV 6
10		30. Name and address of person who	D Seasons H	OSPICE, EIKTO	on, MD	
S	ate	31. Date liled (Month, Day, Year)	32. Registrar's Signature	(Propole)		

06-03994 Please Type or Print in Black Indelible Ink Frank Bernard Slater, Jr. State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1825 hrs **Medical Examiner** June 10, 2006 Frank B. Slater, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2712 Pinewood Waldorf Charles 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24Hrs 9. Birthplace (State or **Funeral** Foreign Co**Wa**sh., DC Months Days Hours Min Director 225-98-2522 $_{1}X_{M}$ 38 08/08/1967 2 F Usual Residence of Deceden É 10a, State 10b. County Oc. City, Town or Location 10d. Inside City Limits DC 1 X Yes 2 No 28a-f show Washington I and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 28a-ast be notified at 2709 Robinson Place, SE #404 20020 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White, etc 2 X No Yes If Yes, Give Year 3 Widowed 4 Divorced 1 Yes 2 X No specify: þ Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than 'injury or other traumatic event, the Medical Baltimore, MD 21215-0036 12th Truck Driver Self-Employed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Frank B. Slater, Sr. Odessa Stokes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jernelle Slater/Wife 2709 Robinson P1. SE #404, Wash., DC 20020 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 6/17/2006 Donation 5 Other Specify: Ft. Lincoln Cemetery Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician List only one cause on each line Between Onset and /Medical a Multiple Injuries Death Immediat Lause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? 2 Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Hospital: 1 Inpatient 2 ER/Outpatient 3

	1 ✓ Yes 2 No	1 🗸 Yes	2 No	
eath (Check	only one)			
	ng Home 5 Residence	Le-said	е	
Work? 2 🗸 No	28d. Describe how injury of motorcycle driver	occurred struck trees		
ng, etc.	28f. Location (Street and N	umber or Rural Rou	ute Number, City	У

autopsy

performed?

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 V No 3 Probably 4 Unknown

death?

24b. Were autopsy findings available

prior to completion of cause of

1 Natural 5 Pending Investigation 2 Naccident 5 Pending Investigation 3 Suicide 4 Homicide Could not be determined (Specify) Local Street

29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date at

32. Registrar's Signa

28a. Date of Injury

icide determined (Specify) Local Street 2712 Pinewood, Waldorf, MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

June 11, 2006

29b. Signature and title of certifier

29c License number 29d Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Margarita Korell MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

26 Place of D

28c. Injury at

DOA

Othe

State Registrar

and

attending physician or use as the burial

has

this

After

Director:

To the Funeral

Q

certificate ector, page

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

Physician/Medical

á

Completed

Be

Certification:

Medical

25. Was case referred to medical

JUN 1 4 2006

2 No

examiner?

(Check only

one)

1 🗸 Yes

Manner of Death

28b. Time of Injury

			1 - For State Registrar	State of M	aryland /					ind M		U	U6	20545
I											2. Date of Dea Month JUNE	Day	Year 2006	3. Time of Death 8:40PM
			4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o	f Death			-	
В	Funeral Director				58	Yrs.	Months	Days	Hours	Min.	DEC 27	1947	SOUTH	lace (State or Foreign fry) CAROLINA
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Lo	cation						10	Od. Inside City Limits
	Maryl	tor	MD HOWARD		LAURE	L								XXYes 2 □ No
	or 28s	Olrec	10e. Street and Number				10f. Zip							,
Pryst clan Checkeder's turner first, videous, Lasey Checkeder's turner first, videous is associated and processed Checkeder's turner first, videous is associated Checkeder's turn														
36	irs after de il', or items Xvioli el Li		1 Never Married XX Married	Armed Forces?	No					gin? (Spo , Puerto	ecify Yes or No- Rican, etc.)		lack, White, e	etc.
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Physician Medical Examiner Fineral Director		life. L	OO NOT us	se retired)				EEDED	AT CON	TTT NIMITATO				
Physician ROBERT LEE STEADMAN ROBERT LEE STEADMAN GOOD TOTAL HALL Funderal Director The complete of the control of the co					EKNMENI									
Physician Medical Examiner Medical Medica					ERA	ROE	BINSON							
Physician Concent Name (First, Models, Last)			•		*									
	1 and Health tem 27			MILE	20b. Place	of Dispo	sition (Nan	ne of	1					
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Balti	permit. Departm Importa eny inju			بالا	/	M7	ARSHA	d Addres LL S	s of Facility FUNE	RAL	HOME OF	MARYL	AND, IN	
	/Medical Examiner	l Examiner	snock or near failure. List only of Immediate Cause (Final disease or condition resulting in death) Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CARDIAC Due to (or as ATHERSO Due to (or as	ARRHYT a consequence SCLEROT a consequence	HMIA of): IC (1							Interval Between Onset and Death
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O. Box	the death certi y the attending iched for use a	nysiclan/Mo	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal deat									ry Day Year
	s that gned b							_	n in Part I.		23e. Did to	bacco use co	ntribute to the	e cause of death?
ord	equire sen sig	ted l	CORONARY ARTERY D	ISEASE, D	IABETES	MEI	LITU	S,			1 🗆 Y	es 2□No	3 Proba	ably XXUnknown
I Rec		Comple	PERIPHERAL VASCULA	AR DISEAS	E	_					autops	SV	prior to con death?	osy findings available npletion of cause of 2 No
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of	Phys this ral di		I Tes ALAINO	1 Inpati				'A	44(71)					")
ion	nding ath. r: Afte e fune	ation	XXNatural 5 ☐ Pending	(Month, Da	y Year)							. ,		
Divis	in Life	Certific	determined	28e. Place of In building, e	jury · At home, t c. <i>(Specify)</i>	farm, stre	eet, factory	, office					nber or Rural	l Route Number,
	Hos 24 h 5ur stely		(Check only 2 Medical Exami	ner: On the basis of	of examination a	ge, death ind/or inv	occurred vestigation,	at the tim in my op	e, date and inion, deal	d place, h occurr	and due to the c ed at the time, d	ause(s) and n ate and place	nanner as sta a, and due to	ated. the cause(s)
	Vilh Tot com		29b. Signature and title of certifier	-C. Su	-an	Ce >	290				2			
0		1					Deine's	וכע	درور			JUNE	09, 2	2006
	4		SUYAN C. SUANA		5851 I	EALI		RCHT	ON RO	AD	DEALE	, MD 2	0751	
	Sta Regist		31. Date filed (Month, Day, Year)	2. Regist		has	KI							

			1 - For State Registrar	State of Marylar	nd / Depa		leaith and	Mental Hygi		20546
	Physici /Medici Examir	cal	1. Decedent's Name (First, Middle, Last Bar bara 4a. Facility Name (If not institution, give The Johns Hop 5. Social Security Number 6. \$6	street and number) Kins Hospi	Ste tal	4b. City, Town, o	r Location of Deat		Day Year O 2000 4c. County of Dea	tholace (State or Foreign
	Director	Director	217-44-5146		Yrs. ty, Town or Lo	Months Days cation	Hours Min.	9-8-1946	Mar Mar	oudity) y Land 10d. Inside City Limits 1X Yes 2 □ No
036	within 72 hours after death with the Maryland ane. then "naturel", or itams 23a or 28a-f show is Madical Examinating.	by Funeral	12259 St. James Ro 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	d. 12. Was Decedent Ever in U Armed Forces? 1 Yes 25 No If Yes, Give Year or Dates:	t	20854 Nas Decedent of H if Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puerl Specify:		U.S.A. 14. Race - Am Black, Whi	erican Indian,
Maryland 21215-0036	filled Hygin thar	Be Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give life. L	dent's Usual Occup kind of work done DO NOT use retired 'eacher	during most of woi	king 1	6b. Kind of Business Public Solution (Control of Business)	·
	ss 1 and 2 should be of Health and Mental item 27 is marked or other treumatic even	ToB	Boris Kameras 19a. Informant's Name/Relationship (T. Sam Steppel — hu: 20a. Method of Disposition	sband	12259	St. Jam	and Number or Ru	otomac, M		
Baltimore,	parmit. Pages. Department of H Importent: If ite eny injury or ot		20a. Metrod of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 1 1 □ Donation 5 □ Other (Specify, 21. Signature 1 Fune v1 Service License)	Ju	dean Me		en 6−12 skeyFa©oldb	-06 erg Memor	Oc. Location - City or Olney, MD rial Chape le, MD 20	1s, Inc.
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequential Vist conditions.	a. Arter Kul S Due to (or as a conseque)	clero			or respiratory arres		Approximate Interval Between Onset and Death
8760,	cate be executad ohysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
P.O. Box 68	The law requires that the death certificat tile has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	ıldeath 3 □	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Vital Records, F	e law requires tha has been signed je 2 should be det	Completed by F	Part 11. Other significant conditions co Diabetes mellin Cerebral Vascu	,		nderlying cause giv	en in Part I.	23e. Did toba 1 Yes 24a. Was an autopsy	No 3 □ P	robably 4 Unknown utopsy findings available completion of cause of
ot	Physician: this certifica ral director, p	To Be	27. Manner of Death 1 Natural 5 □ Pending	Hospital: 1 (inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun Work	er: 4 Nursing H	perform 1 ☐ Yes 2 th Check onl one	ed? death? No 1 Yes	: 2□ No
Division	Atten ar deat actor: by tha	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	building, etc. (Specif	(y)	eet, factory, office	Yes 2 □No	City or Town,		
)	To the Hospitel or within 24 hours after To the Funerel Dir completely fillad in	Medical	29a. Certifier (Check only one) 1 Certifying Phy (Check only one) 29b. Signature and title of certifier	vsician: To the best of my knotiner: On the basis of examina and manner stated.	owledge, death	29c. Licenso	pinion, death occu	rred at the time, dat	ise(s) and manner as e and place, and due d. Date signed (Mont	e to the cause(s)
:	Sta Registi		30. Name and address of person who company burns 31. Date filed (Month, Day, Year) JUN 15 2	ompleted cause of death (Iten	Hopl	Kins Ho	spital	600 N. W6	IfeSt Pal-	fimore MD

			1 - For State Registrar	State of M	aryland	-			lealth a			giene (06	20547
Т			1. Decedent's Name (First, Middle, Las	it)							2. Date of Dea	ith Day	Year	3. Time of Death
	Physici /Medio		Nancy Ellen	Schapiro	1						June	12,	2006	9:30 p ^M
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			4 Farsta Court				Ro	ckvi	11e			Mo	ntgome	ery
	Funeral		Social Security Number 6. S	9X 7. Ag □ M 2 🔀 F	ge (In yrs. la:		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt	Year)	9. Birthp	lace (State or Foreign try) York
	Director		092-38-6832	- M 2LAF	59	9 Yrs.					(Month, Da) April 3	0,1947	Nev	York
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation						1	0d. Inside City Limits
	/anyli	ö		m 0 % 17		kvill							Ι.	1⊠Yes 2 □ No
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	with 3a or		4 Farsta Court					20850)			_	ed Sta	•
	ns 23	Funeral	11. Marital Status	12. Was Decedent		. 13.1				gin? (Sp	ecity Yes or No-		ace - Americ	
0	r Her	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💆						i, Puerto	ecify Yes or No- Rican, etc.)	1	lack, White,	etc.
3	el', o	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2K No	Specify:			Spe	cify: Cauc	asian
215-0036	tiled within 72 hours atter death with the Maryland Hygiene. tither then "naturel", or Hems 23e or 28e-f show inther then "naturel", or Hems 23e or 28e-f show ont, the Medical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dece	dent's Usus	al Occupa	ation	t of work	ina		Business/Ind	
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and	be filed ital Hygi od other event,	Be	17. Father's Name (First, Middle, Last)	11							e (First, Middle,		ате)	
>	i Mer Marke Parke	P L	Harry Paul Sewe								Doris			
Ma	12 st h and 7 is n treun		19a. Informant's Name/Relationship (7								al Route Numbe			Code)
	Healt Healt Healt ther		Rebecca B. Mollo 20a. Method of Disposition	y/ Daugnt							, New Y		DU4 n - City or T <i>o</i>	State
و	8 = = 0		1 ☐ Burial 2 🖾 Cremation 3 ☐			ce of Dispo								
saitimore,	rtmer rtent njury		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licenters 		Ft.						9/2006	Bren	twood,	Maryland
g	permit. Pages 1 and 2 should be fill Department of Health and Mental H Importent: If tiem 27 is marked out en y injury or other treumatic even once.		21. Signature of Funeral Service Licen	-		Si 10	imple 040 R	Tril	s of Facility oute ille	Fune Pike	ral and ; Rockv	Crema	tion C Maryla	enter nd 20852
	District		23a. Part 1. Enter the disease, or comp shock, of heart failure. List only Immediate Cause (Final				er the mod	le of dying	g, such as	cardiac o	or respiratory are	est,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Liver M										1 month
	Examiner			Small C	·	,								
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	nce of):								
	cuted nd ransil	Examiner	that initiated events	C										
ĵ	be executed ician and burial-transit		resulting in death) Last	Due to (or as	a conseque	nce of):								
9/90	ate nys	Icai		d.										
Õ	certifica nding pt use as t	Med	IF FEMALE:											
POX	death certific e attending pl ed for use as f	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐Live birth	2 Fetal d	leath 3	Ectopic pr					1	Date of delive Month	ry Day Year
	D 0 5	/sic	1 ☐ Yes 2 ☐ No 9 🖾 Unknown	4□Pregnant a 9□Unknown	t time of dea	ith 5∐	Other (sp	ecify)						ouy rou
ŗ	that thed by	Ph)	Part II. Other significant conditions of	entributing to death h	out not result	ing in the u	ndoshina a	aueo aiua	n in Part I		23e Did to	hacco use co	ntributo to th	e cause of death?
Ś	es be	l by	Tan, ii. Sales significant contained	onthibuting to doubt t	Jat 1101 103an	mg in the di	idenying c	auso give	ni iii i catti.					ably 4 🖾 Unknown
ecoras,	w requir been s should	etec												
ခို	Blaw has b	ompleted									24a. Was a autop: perfor	sy	. Were autop prior to con death?	sy findings available apletion of cause of
<u> </u>	: The licate hat; page	O									1□ Yes		1 Yes	2□ No
Vital	ysicien: The lav is certificate has director, page 2	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only or			
5	d is	. To	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Inju		R/Outpatien 8b. Time of		- Date process	4 🗆 140		me 5 🔀 Residence 128d. Describe he)
	ding Ph h. After th funeral	tion	1 XNatural 5 ☐ Pending	(Month, Da	y Year)	Injury	м	8c. Injury Work	.? ′es 2 □ l		20d. Describe III	ow injury occ	alled	
VISION	death ctor: y the	ertification:	3 Suicide 6 Could not be		iury - At hom	e farm str				_	28f. Location (S	reet and Nur	nher or Ruml	Route Number
2	el or A s after s Dire	Certi	4 Homicide determined	building, et	tc. (Specify)	,,,	001, 140101	, 511100			City or Town			, iodio ridingoi,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 ☑ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best liner: On the basis o and manner st	of examinatio	edge, death n and/or inv	occurred restigation	at the tim in my op	e, date an inion, deal	d place, a	and due to the c ed at the time, d	ause(s) and r ate and place	nanner as sta e, and due to	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier				290	. License	number		2	9d. Date sign	ed (Month, E	Day, Year)
			1 1th	110				06005	50			June	14, 20	06
	10		30. Name and address of person who d	completed cause of c	death (Item 2	23a) (Type,		- 5 5 0 2	-			June	_ ,	
			Mahrukh Musharraf	Hussain,	M.D.				tile :	Lane	; Largo	, Mary	land 2	0774
	Sta		31. Date filed (Month, Day, Year)		rar's Signatu	re 🗾	arte							
	Registr	ar	JUN 15 2	2006 1000	see B	La Val								

State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 💍 20548 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 2006 MaryCollette Smith JUNE 13 7:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** COASTAL HOSPICE AT THE LAKE WICOMICO SALISBURY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. DEC 17, 1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F PENNSYLVANIA 73 Yrs 192-24-5041 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d, Inside City Limits 10b. County item 27 is marked other than "natural", or Items 23a or 28e-f show other treumatic event, the Machical Examinar must be notified at 1 X Yes 2 No Directo DELAWARE SUSSEX SELBYVILLE 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 8 MILL POND DRIVE 19975 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) REGISTERED NURSE HEALTHCARE Pages 1 and 2 should be filed a nent of Health and Mental Hygie out: If item 27 is marked other? 17 Father's Name (First Middle Last. 18. Mother's Name (First, Middle, Maiden Sumame) Be **EVAN** MOSES ANN FLYNN ဂ္ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 MILL POND DRIVE, SELBYVILLE, DELAWARE 19975 ARTHUR T. SMITH/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State MD VETERANS CEM. 6/20/06 * 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 MO1343 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Exami the attending physicien and thed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death detached 9☐ Unknown 9 Tillnknown ģ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 12 Yes 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy death? certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 In atient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2⊠ No ٩ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation n 24 hours after death.

The Funerel Director: A pletely filled in by the fi death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the I 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) SUAL arra 31. Date filed (Month, Day, Year) Registrar's Signatur State Registrar 5

Elizabeth Anne Sweeney

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Certifica	te of L	Death			Re	eg. No.	00	0 2004
Physici	an/	Decedent's Name (First, Middle, I	ast)					2	Date of Dea Month			3. Time of Death
Medical Exam	iner	LIIZADCCII IIIIC		_					June 10, 2	2006		1620 hrs
		4a. Facility Name (if not institution, Bowie Health Center	give street and number)		1 .	City, Town, or Bowie	Location o	of Death		4c. County Prince ('e
Sa.			Sex 7. Age (I	n yrs. last birth		If Under 1 Yea	ar liftindo	er 24Hrs.	8 Date of Bir			
Funeral Director		217-32-0239	M 2[X]F	69	-	Months Day		Min.	01/12	/1937	Foreigr Cou	nplace (State or Washington Intry) DC
à		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town o	r Location						— т	10d Inside City Limits
d 10 w a		Maryland Prince	Coorgo's	Bowie								1 X Yes 2 No
ırylan Sa-f sl	cto	10e. Street and Number	George 5	DOWLE	1	Of. Zip Code			1	0g. Citizen of W	hat Coun'	
th the Maryland 23a or 28a-f show any notified at once.	Dire	12712 Buckingha	m Drive			20715				USA		,
with th 18 23a 9e noti	ral	11. Marital Status	12. Was Decedent Ev	er in U.S.		Decedent of His					- Americ	an Indian, 8lack,
death or iten	Funeral Director	1 Never Married 2 X Marr	ied Armed Forces?	No	If Yes,	specify Cuba	n, Mexican,	Puerto R	ican, etc.)	Whit	e, etc.	
after a al", o	by F	3 Widowed 4 Divorce	ced If Yes, Give Year or Dates:		1 Y	es 2 X No	specify:			Specify:	Whit	te
hours natur Exam		15. Decedent's Education (Specify		d		Usual Occupa of working life				16b. Kind of 8t	usiness/In	ndustry
0036 within 72 hours after death with the Maryland free than "natural", or items 23a or 28a-f She Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		- M.1					0 17		
-00; d with griene ther t	mo	12 17. Father's Name (First, Middle, La	ast)	Ноп	e Mal	ker	18 Mother's	s Name (I	irst Middle M	Own Hor		
21215-0036 und be filed within 7 Mental Hygiene marked other than c event, the Medica	Be C	John Lee Thew	,						Matto		,	
213 ould b il Men	To	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing A					ber, City or Tow	n, State,	Zıp Code)
MD id 2 sho lith and m 27 is		William E. Swee	ney/ Husband					rive	Bowie	, MD 20	715	
re, s l an f Heal If iten er tra		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from State		Disposition of their	n (Name of ce place)	metery,		Date	20c. Location	City or T	Town, State
MO Page: nent o ant:		4 Donation 5 Other Spec	ifv:	Fort L	incol	Ln Ceme	tery	06/1	5/2006	Brentwo	ood,	MD
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after begartment of Health and Mernal Hygens III Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	1 3	21. Signature of Funeral Service Lie	censee		22. Nan	ne and Addres	s of Facility	Robe	rt E.	Evans Fu	inera	al Home
	V) V	My			1600	00 Anna	polis	Roa	d Bowi	e, MD 20)715	
Physician /Medical		23a. Part I. Enter the disease, or co failure. List only one cause or	each line.					ardiac or r	espiratory arre	est, shock, or he	art	Approximate Interval 8etween Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ		Cardiov	ascular Dis	sease					Death
			b.	lerice or).								
	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):								
	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):	_		_			_		
cuted nd ransit		ovomo vobaning iii doddii je Edot	d	ŕ								
8760, ifficate be executed g physician and is the burial - transit	ledical	UNPENDED	AMENDED					-				
8760, iificate bung physic	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome							23d Date of		
ന 🛱 🚉 🔊	ian	past 12 months?	1 Live birth Pregnant at time	e of death 5			Ectopic	pregnanc	У	Month	Da	ay Year
Box 68 Le death certif the attending	Physician/M	1 Yes 2 V No 9 Unkno		5	Other	(Specify)						
- + ≳2		Part II. Other significant condition	s contributing to death be	ut not resulting	in the und	erlying cause (given in Par	rt I.	23e. Did to	bacco use contr	ibute to th	ne cause of death?
ords, P.C	d by								1 Yes	2 No 3	Proba	ably 4 🗸 Unknown
Division of Vital Records, tal or Attending Physician: The law requir atter death. al Director: After this certificate has been sited in by the funeral director, page 2 should t	Completed								24a. Was a			opsy findings available impletion of cause of
Vital Reconsystems: The law this certificate has I director, page 2 s	шо								perfor		death?	2 No
al Rian: 1	Be C	25. Was case referred to medical				26.Place	e of Death (Check on	ly one)		1.5	
ision of Vital I Attending Physician: or death. ector: After this certifi by the funeral director,	2	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 🗸 ER/Out			Other ₄	Nursing	Home 5	Residence 6	Other:	
ing Ph After I	<u>ج</u> ا	27. Manner of Death 1 ✓ Natural 5 □ Pandia	28a. Date of Injury (Month, Day, Year)	28b. Ti	me of Inju		iry at Work?		8d. Describe h	ow injury occurr	ed	
ivisior or Attend after death Director:	atic	2 Accident Pending	ation				Yes 2					
Division pital or Attent ours after death eral Director: filled in by the	Certification:	3 Suicide 6 Could r		/ - At home, far	m, street, f	actory, office b	ouilding, etc	c. 2	Bf. Location (S or Town, S		er or Rura	al Route Number, City
ospits hours unera ly fille		4 Homicide	Trapasing			l - 1 11 - 1	-1					
Division To the Hospital or Attention within 24 hours after death To the Finneral Director:	Medical	(Check only	sician: To the best of my ki ner:On the basis of examin									
To with	Mec	29b. Signature and title of certifier	and manner stated			29c. Licens	se number			29d Date sign	ed (Mont	h, Day, Year)
		/ah:1110	244.			O.C.	M.E.			June 11, 2	· ·	
		30. Name and address of person wi	no completed cause of deat	h (Item 23a)		1						
		Zabiullah Ali, M.D. As	sistant Medical Exar	miner 11	1 Penn	Street, Balt	imore, N	1D 2120	01			
	tate	31. Date filed (Month, Day, Year)	2006 32. R distrar's	Signature	La	K.					-	
Regis	trar	JUN 14	LUUU	10	A STATE OF THE PARTY OF THE PAR							

		1 - For State Registrar		,		ertificat			Mental Hy	Reg. N	_ U U	0	4U	CC
		1. Decedent's Name (First, Middle, L	ast)						2. Date of D Month	eath		ear 3	. Time of	f Death
Physicia /Medic		Lorraine Frances S	chultheis	Z						11.	_2006		9:02	p
Examin		4a. Facility Name (If not institution, gi	ve street and nur	mber)		4b. City,	Town, or Lo	ocation of Deatl			c. County of I	Death		
		Suburban Hospital					Betheso					gomery		
Funeral		5. Social Security Number 6. 536–28–8335	Sex 1□M 2⊡xF		s. last birthday 'F Yrs.	/) If Under Months		f Under 24 Hrs. Hours Min.	(Month, D	ау, Үөа	17)	Birthplace Country)		or Forei
Director		Usual Residence of Decedent		/	5 Yrs.				Jan. 9,	193	1 V	Vashing	gtan	
» =		10a. State 10b. County		10c. C	ity, Town or L	Location						10d.	Inside C	ity Limi
Deportment of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Exercipar most be publiced at once.	to	Maryland Montgome	rv		Bet	thesda							1 🗌 Yes	2 <u>k</u>
or 28a-f show	Director	10e. Street and Number				10f. Zip	Code			10g. C	Citizen of Wha	it Country?	?	
23a o		5900 Walton Road				208	817							
E E	Funerai	11. Marital Status	12. Was Dece	edent Ever in	U.S. 13	. Was Deced	dent of Hispa	anic Origin? (S Mexican, Puert	pecify Yes or N	0-	USA 14 Race -	American I White, etc.	ndian,	
or the	F	1 ☐ Never Married 2 ☐ Married	1 X Yes	2 🗆 No		1 ☐ Yes		Specify:	o moun, otc.,		1			
Ex	d b	3	Year or D	ates: 1951	- 54						Specify: Wh	ite		
100	Completed by	15. Decedent's E (Specify only highest g			(Giv	edent's Usua e kind of wo	rk done duri	on ing most of wor	king	16b.	Kind of Business/Industry			
W W	mp	Elementary/Secondary (0-12)	College (1	I-4or 5+)	_	DO NOT us					~			
ŧ	ပ္ပ	17. Father's Name (First, Middle, Las) Se	cretary		Mother's Nan	ne (First, Middle		Governme	nt		
*	Be	Harry Dankart Hans							e Caufiel		on Sumame)			
į	2	19a. Informant's Name/Relationship			10h Mai	ling Addrose			ral Route Numb		or Town Sto	to Zin Co.	de l	
tra					-1					_		16, 21p Co	J6/	
# # C		Janet Schultheisz/ 20a. Method of Disposition	<u> vaugnter</u>	20b.	Place of Disp cemetery, cre	position (Nan	ne of	Bethesd	, Maryla Date		0817 Location - City	v or Town.	State	
		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		13,	Alexandria, Virginia									
Ju .		21. Signature of Funeral Service Lice	·	IIR	tropolit				006 1	lexa	endria, '	Virgin	ia	
any i	Н	Q Kai St. Ca							eral Home					
		23a, Part1, Enter the disease, or cor	nolications that c	aused the dea	ath. Donot er	nter the mod	ersity	Blvd, W,	Silver S	Sprir	ng, MD 2		proximat	te
nysician Medical		23a. PM.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final												
	disease or condition resulting in death)		y Tract		on						D	avs		
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	er	Sequentially list conditions, it any, leading to infinediate						-						
the burial-transit	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				Day	s							
100	Exa	resulting in death) Last	Due to (or as a conse	quence of):									
2	dicai		d Malnut	rition								Dav	vs	
	Med	IE ECMALE.				-					Ē:			
r use	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out 1□Live b	come of pregr		□Ectopic pr	egnancy				23d. Date of			
od be	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No		ant at time of		Other (sp.					Month	Day	, 1	Year
etach	Phy	9 Unknown							_					
		Part II. Other significant conditions	contributing to de	eath but not re	sulting in the	underlying ca	ause given i	n Part I.			use contribut			
should should	Completed	Sacral Decubitus Ulo	cer						1 🗆	Yes 2	2.23 No 3.□ ————————————————————————————————————	_ Probably	4 🗆	Jnknow
S CI	pie								24a. Was		24b. Were	e autopsy to comple	findings	availab
page	ő								perfo 1 ☐ Yes	ormed?	deat	h? Yes 2□		
octor,	Be	25. Was case referred to medical examiner?					26	3. Place of Dea	th Check only	one)				
this certificete al director, pag		1 ☐ Yes 2 ⊠No	Hospital:	npatient 2	☐ ER/Outpatie				ome 5□Resi	dence	6 ☐Other (Specify)		
Atter t	Ë	27. Manner of Death 1 ☑Matural 5 ☐ Pending	28a. Date ((Mont	of Injury th, Day Year)	28b. Time of Injury	of 2	8c. Injury at Work?		28d. Describe	how inj	ury occurred			
2 g	cati	2 Accident investigation	no			М		2 🗆 No						
o by	Certification; To	3 Suicide 6 Could not determined	289. Place	of Injury - At I	home, farm, si	treet, factory	, office		28f. Location (City or To	Street a wn, Sta	and Number o te)	r Rural Ro	ute Num	ber,
De l			1											
	Medicai	29a. Certifier 1/2 Certifying P (Check only one) 2 Medical Exa	hysician: To the miner: On the ba	asis of examin	nowledge, dea nation and/or in	ith occurred a nvestigation,	at the time, in my opini	date and place, on, death occur	, and due to the rred at the time,	cause(: date ar	s) and manne nd place, and	r as stated due to the	l. cause(s	;)
le y		29b. Signature and title of certifier	and mann	ner stated.	1,	290	. License nu	mher		394 D	ate signed (M	Innth Dev	Vearl	
ompletely	Mec	290. Signature and title of certifier	1.			250					orginad (M	J, 20y,	. Jai /	
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To the Fun completely	Mec	Souma	Kh	omo	y r		D 58	965		Ĵί	me 12,	2006	,	
To the Funeral Director: completely filled in by the	Mec	30. Name and address of person who Saima Khawa ja, M.D.						8965 e, MD 208	352	Ji	me 12,	2006	,	

		•	For State Registrar	State of	Marylan		artment of H			giene Reg. Not	00	20	551
, e	4		Decedent's Name (First, Middle,	Last)					2. Date of De	ath		3. Time o	of Death
	Physicia	_	JAMES VINCENT SCALA	1					JUNE 12	Day 2006	Year	6:38	A M
	/Medic Examin		4a. Facility Name (If not institution,		ber)		4b. City, Town, or	Location of De		4c. Count	y of Death	1	
	- LAGITIM		MONTGOMERY GENERAL	HOSPITAL			OLNEY			MONTGO	OMERY		
	Funeral		5. Social Security Number		. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 H		h v Year)	9. Birth	place (State intry)	or Foreign
	Director		066-10-1782	1 XM 2 ☐ F	87	7 Yrs.	Months Days	riours ivi		27, 1918			
	D .		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	cation					10d. Inside (hy Limite
	ehow	'n											2 🔼 No
	he N	Director	MARYLAND MONTGOME 10e. Street and Number	LRY	SILV	ER SPRIN	10f. Zip Code			10g. Citizen of	What Cou	intn/2	
	with a or										Wilat Cot	ntity:	
	eath	Funeral	3330 N. LEISURE WOF	RLD BLVD., AI		S 13 1	20906 Was Decedent of Hi	spanic Origin?	(Specify Yes or No	U.S.A.	ce - Amer	ican Indian,	
	iter d	'n	1 ☐ Never Married 2 Marrie	Armed Ford	es?		f Yes, specify Cuba	n, Mexican, Pu	erto Rican, etc.)		ack, White		
93	irs af	by i	3 Widowed 4 Divorced	If Yes, Give Year or Dat		1	1□Yes 2█No	Specify:		Spec	ty: WHI	TE	
ŏ	within 72 hours after death with the Maryland ene. Than "naturel", or Itema 23a or 28a-f ehow he Madical Examiner must be notified at	ted	15. Decedent				dent's Usual Occupa			16b. Kind of I	Business/li	ndustry	
75	hin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-	4or 5+)	lite.	kind of work done of DO NOT use retired	ruring most of i)	vorking				
2	d wit giene grithe	NO.	12			EXECUT	IVE			U.S. GOV	ERNME	NT	
Maryland 21215-0036	be filed tal Hygid d other event,	Be	17. Father's Name (First, Middle, L	.ast)				18. Mother's N	lam <i>e (First, Middle</i>	Maiden Suma	me)		
<u>ā</u>	should b ind Ments i marked umatic e	0	JAMES	SCALA				CARMELA		BARRON	IO		
al L	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Marala Hygiens. Interportant: It fem 27 is marked other than "naturel", or Itema 23a or 28s-1 ehov any injury or other treumatic event, the Macical Examiner must be notified at once.		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street a	and Number or	Rural Route Numb	er, City or Town	, State, Zi	p Code)	
	and and m 27		JAMES A. SCALA/SON			_	OLONIAL OAK	COURT,					
Baltimore,	Sa Tage		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □ Removal from S	1 ,	Place of Dispo cemetery, crer	sition (Name of natory or other plac	θ)	Date	20c. Location	- City or T	own, State	
Ĕ	Pages ment of land		4 Donation 5 Other (Sp	_		RT LINCO	LN CEMETERY	06/	15/2006	BRENTWOO	D, MAI	RYLAND	
a a	Departi Departi Importi any in		21. Signature of Funeral Service L	icense	*	22 HT	2. Name and Addres NES-RINALDI	s of Facility	HOME. INC.				
Ш_	70 E # 9		Umanday	Kudew	ra	11	800 NEW HAM	PSHIRE A	VENUE, SILV	ER SPRING	, MARY	ZLAND 20)904
			23a. Part1. Enter the disease of shock, or heart failure. List of	complications that can only one cause on ea	us of the deat ch line.	th. Do not ent	er the mode of dying	g, such as card	liac or respiratory a	rrest,		Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition	ACUTE R	ENAL FA	ILURE						Onset and 24 HOU	
Į:r	/Medical®		resulting in death)	a	ras a conseq								
145	Examiner		Sequentially list conditions	b	TIC CAN							3 MONT	.HS
16	D ==	ne	if any, leading to immediate cause. Enter Underlying	Due to (o	ras a conseq	quence of):							
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	r as a conseq						_		
8760,	cate be executed bhysician and the burial-transit		, and a second of the second o	00 00 (0	r as a conseq	(uerice oi).							
87	th th	dical		d							-		
9 ×	death certifica e attending ph ed for use as t		IF FEMALE:	23c. If yes, outco	ome of pream	2001							
Вох	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	th 2 ∏ Feta ntattime of d	al death 3	Ectopic pregnancy				ate of deliventh		Year
o.	0 0 2	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregna 9□Unknov		Jeath 5∟	Other (specify)						
۵.	The law requires that the de ate has been signed by the bage 2 should be detached	F.	Part II. Other significant conditio	ns contributing to dea	ith but not res	sulting in the u	nderlying cause give	on in Part I.	23e. Did t	obacco use cor	ntribute to	the cause of	death?
ds,	sign d be	1 by				-	, ,		10	res 2 🗓 No	3 ☐ Pro	bably 4	Unknown
Ö	w requir been s should	Completed							24- 146-	24	144	Cada	
ě	has has le 2 s	ш							24a. Was		prior to co death?	opsy findings ompletion of	cause of
									1□ Yes	2 🖾 No	1 ☐ Yes	2□ No	
Ħ	Physician: this certificanal director,	Be	25. Was case referred to medical examiner?	Hospital:			othe Othe	ac .	Death Check only o				
ō	D = 6	.T	1 ☐ Yes 2 🖾 No 27. Manner of Death	28a. Date of		ER/Outpatier 28b. Time of	II SELDON	4 🗀 IVUI SIRI	Home 5 Resident			ify)	
n O	ding After fune	tlon	1 ⊠Natural 5 ☐ Pending	(Month	, Day Year)	Injury	Work	ເ?ົ Yes 2∐No	200. 00000	ion injury cood			
S	or Attending after death. Director: After in by the fune	lica	3 ☐ Suicide 6 ☐ Could n	ot be 390 Place of	of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (Street and Num	ber or Rur	al Route Nur	nber.
Division	after after Dire	Certification;	4 Homicide determi	building	g, etc. (Specii	fy)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	vn, State)			
	Hospitel 24 hours 2 Funerel 1 stely filled		29a. Certifier 1 🖔 Certifying	g Physician: To the t	est of my kno	owledge, deati	n occurred at the time	ne, date and pla	ace, and due to the	cause(s) and m	ianner as :	stated.	
	• Ho • Ful	edical	(Check only 2 Medical E	examiner: On the base and manner	sis of examina	ation and/or in	vestigation, in my op	oinion, death o	ccurred at the time,	date and place	and due	to the cause(s)
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier	14			29c. License	number		29d. Date sign	ed (Month	Day, Year)	
	30		Dewell 1	Morris	-W)		D4768	2		JUNE 12,	2006		
•	7		30. Name and address of person v		of death (Iter	п 23a) (Тур <i>ө</i> ,							
			BENNETT MORRISON, M					EY, MARYI	AND 20832				
	Sta	ite	31. Date filed (Month, Day, Year)			ature							
310	Registr	ar	JUN 14	F SOMP	sure s	A PAR	A STATE OF THE STA						

			1 - For State Registrar	State of Ma	arylan		artmen rtificat			and Me		jienę 2	005	20552
	Physici	an	Decedent's Name (First, Middle, L.			Co					Date of Dea Month	th Day	Year	3. Time of Death
	/Medic	al	Lois 4a. Facility Name (If not institution, gi	Maria		Se'	well	Town or	Location o		vue	12	200 6 ounty of Deatl	1557 FM
	Examin	er	Union Hospital	0	Co	54 47	, ,	KTU		or Death		Ced	•	1
9	Funeral			Sex 7. Ag		last birthday)	If Under	1 Year	If Under		Date of Birth)	9. Birtl	nplace (State or Foreign
	Director		218-26-2931	1 M 2 M F	74	Yrs.	Months	Days	Hours	Min. 12	Month Day 2-27-	1931	Elĸ	ton
7.	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
	hours after death with the Maryland tural', or iteme 23a or 28a-f ahow al Examinermual be notified at	ō	MD Cecil			sapea		City						1⊠Yes 2 No
	28a-	Director	10e. Street and Number		1		10f. Zip					10g. Citize	on of What Co	untry?
	3a ou	D E	105 Pine Str	eet			21	915				US	A	
	deat me 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Was Dece	dent of Hi	spanic Orig	gin? (Specif	y Yes or No- an, etc.)	14	Race - Ame Black, White	
ဖွ	after or its		1 XNever Married 2 Married	1 Yes 2 X		1	1 🗆 Yes			i, Fuello Filo	an, otc.,		pecify: b1	
21215-0036	72 hours after de natural; or iteme	d by	3 Widowed 4 Divorced	Year or Dates:										
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12	within iene.	шо	Elementary/Secondary (0-12)	College (1-4or :	5+)	nurs				it		Hosp	oital	
	al Hygi other vent, I	Bec	17. Father's Name (First, Middle, Las	st)		-			18. Mothe	r's Name (F	irst, Middle,	Maiden S	umame)	
<u>Jar</u>	Mental Mental arked o	ို	Perry	H. Sewell	, S:	r.			Edn	a Ge	rtrud	e (E	lughes)
Maryland	2 she and ls m		19a. Informant's Name/Relationship				-						Town, State, Z	
	s 1 and f Health item 27 other tr		A. Ronell Youn 20a. Method of Disposition	g	20h F					Ches			ty, M	ישו
Baltimore,	00		1 X Burial 2 ☐ Cremation 3			Place of Disponentery, crea					1	Ches	apeake	j City
퍒	permit. Page Department Important: Il any injury o		4 ☐ Donation 5 ☐ Other (Spec		1/	hemia				-17-2		ID tuar	37	
Ba	permit. Departm Importai any inju		Take II	1/180	1/2	2	38 E	. 35	this	t. 9₩	ilm.,	DE	¥9802	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	the deat	h. Do not en	er the mod	de of dying	g, such as	cardiac or re	espiratory ari	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				45							Onset and Death
**	/Medical		resulting in death)	Due to (or as								_		.6.1
į,	Examiner		Sequentially list conditions,	b. Aspin	at or	a Pu	وسرساه	uitei	a4-{	2 py	evyou	4		48 4000
	be sis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uerice oi).				,				2 days
_	be executed sicien and burial-transit	хап	that initiated events resulting in death) Last	c. Parq Due to (or as	a conseq	juence of):	leus							0 0 0 0 0
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99	ificate g phys as the			U		-								
Вох	death certifica attending ph d for use as th	M/ul	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			DEctopic p	reanancy				23	d. Date of deli	*
m.	death	sicia	in the past 12 months? 1 ☐ Yes 2 No	4□Pregnant a 9□Unknown			Other (s						Month	Day Year
P.O.	that the de led by the a detached f	Physician/Med	9 Unknown								00 B:11			
	res tha signed I be det	þ	Part II. Other significant conditions Metastatrc				, ,		en in Part I.		23e. Dia to		/	the cause of death?
0.0	w require been signal	eted			11	-4/61	400	٩						
of Vital Records,	elaw hast je2s	Completed	Type II Diab	e +e3					-		24a. Was a autop perfor	sy	24b. Were au prior to death?	topsy findings available completion of cause of
a	hystotan: The Is his certificete har I director, page 2	e Co	25 Mas seen referred to modical			-				(B) 11 (6	1 Yes	2 / N o	1 ☐ Yes	2 □ No
<u> </u>	s certi	To Be	25. Was case referred to medical examiner? 1 Yes 25 No	Hospital: 1 Inpatie	ent 2	ER/Outpatie	nt 3 🗆 D0	Othe	\C		Check only or 5 □ Resid		□Other (Spec	nh()
10	g Phy er this		27. Manner of Death	28a. Date of Inju	ıry	28b. Time of		28c. Injury Work			d. Describe h			,
<u></u>	ath. rr: After ne funer	atio	1/⊠Natural 5 ☐ Pending 2 ☐ Accident investigat	on	y 16a1)	Inquiy	М		r Yes 2 🔲 I	No				
Division	or Attending utter death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At h	ome, farm, st	reet, factor	y, office		28f	Location (S City or Tow		Number or Ru	ral Route Number,
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	To the Hospital or Attendin within 24 hours after death. To the Funerel Director: Att completely filled in by the fun	Medical	29a. Certifier 1 Certifying 1 (Check only one)	Physician: To the best aminer: On the basis of and manner st	f examina	owledge, deat ation and/or in	n occurred vestigation	at the time n, in my op	ie, date an pinion, dea	d place, and th occurred	at the time, o	ause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier	1			29	c. License	number				signed (Monti	
	F \$ ₩ Ö		· anhe as	Lung			b	00	55/	90		June	12	2006
	n		30. Name and address of person wh	o completed cause of c	death (Iter	n 23a) (Type,	Drink							
	3		Alfred A Pir		06 1	Bow s	+ U	4104	, Ho.	spite	131	Kto	4 ME	15815
100 mg	Sta Regist		31. Date filed (Month, Day, Year) JUN 1 4 2006	Seem 32. Registr	rar's Signa	book								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** June 15, Aaron Joseph Shaffer 2006 10:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Long View Nursing Home Manchester Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Hours Min. June 2, 1916 Arcadia, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2□ F Yrs. 90 577-07-8279 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County show rai', or Itams 23a or 28a-f shov Exeminer oust be notified at Carroll Westminster 1 ☐ Yes 2X No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 1133 Old Manchester Road 21157 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: or I 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced The Mudical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Custom Builder Construction permit. Pages 1 and 2 should be filed be Department of Health and Mental Hygie Important: If itam 27 is marked other; any injury or other traumatic event, Ills once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Edward Shaffer Bessie Mae Davidson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 1133 Old Manchester Rd. Westminster, MD Helen L. Shaffer - wife 200 6 Coc. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) June 16, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crematory Winfield, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Myers-Durboraw Funeral Home, P.A. M01191 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, onset and load of loads of load A Thero relevation Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ted Complet 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes 2 410 1 Tyes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28b. Time of 27. Mannox of Death 1 Natural 28d. Describe how injury occurred Certification: After To tha Hospital or Attanding 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To tha Funaral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tiffe of certifier D15872 MD address of rson who complete cause of death (Item 23a) (Type, Print) 30. Name an mai 32. Regitrar's Signature 31. Date filed (Month, Day, Year) JUN 1 6 2006 Registrar

		For State Registrar		Maryland / Dep <i>Ce</i>	artment of rtificate o				Reg. No.	10.5	2055
Physici	an	Decedent's Name (First, Middle, Eugenia	Margaret	Styers				Date of Dea Month une	Day	2006	3. Time of Death 9:30P
/Medic Examin		4a. Facility Name (If not institution,			4b. City, Towr	n, or Location of E			4c. Coun	ty of Death	
	£*	Northampton Man			Frede		U I			rede	
Funeral Director		5. Social Security Number 267-10-7799 Usual Residence of Decedent	6. Sex 1 □ M 2 🕇 F	Age (In yrs. last birthday 86 Yrs.	Months Day		Min. 8.	Date of Birt (Month, Da ept. 2	8,1919	New New	place (State or Foreig ntry) York
yland		10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside City Limit
e Mar	ctor	MD Frede	rick	Wood							1 Tes 2 X N
ter deeth with the Marylan Items 23e or 28e-f show Inst.must be notified at	Funeral Director	10e. Street and Number 12168 Clyde	Vouna Rd		10f. Zip Cod	° 21798			10g. Citizen of		ntry?
ns 23	eral	11. Marital Status	12. Was Deceder	nt Ever in U.S. 13.		of Hispanic Origin Cuban, Mexican, F	? (Specify	Yes or No		ace - Amer	
n 72 hours after deeth with the Maryland "natural", or items 23e or 28a-f show edical Examinat must be notified at	by Fur	1 ☐ Never Married 2 ☐ Marri 3 街 Widowed 4 ☐ Divorced	Armed Force ad 1 Yes 2 [If Yes, Give Year or Date] No	1 ☐ Yes 2X 1		Риепо ніс	an, etc.)	Spec	ack, White <i>ify:</i> Whi	
72 hou natura	ted	15. Decedent (Specify only highes	s Education	16a. Dece	edent's Usual Oc	cupation	f working		16b. Kind of		
C * 3	Completed	Elementary/Secondary (0-12)	College (1-4c	or 5+)		ne during most o tired)			11	- 1 /D	. 6
ill Hygiene. Other than		12 17. Father's Name (First, Middle, I	ast)	Reg	istered		Name (F	irst, Middle,	Maiden Suma		t. Duty
lid be kad o	To Be	Harry Albert				War	nda M	arie	Morris		
ges 1 and 2 should be t of Health and Mental If Item 27 Is marked or or other trsumatic eve		19a. Informant's Name/Relationsh Peggy S. Offut				eet and Number of					
s 1 and the Healt		20a. Method of Disposition	- adagnet	20b. Place of Disp cemetery, cre			Date	-	20c. Location		
Pages nent of h ant: If Ite ury or of		1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		Chapel			/20/2	.006	nr. Lib	erty	town, MD
permit. Page Department of Important: If sny injury or once.		21. Som street Funeral Service 1 23a. Part 1. Enter the disease, or shock, or heart failure. List), Wart	ler	404 S. M	dress of Facility Main St.	Wo	odsbo	ro, MD		3
Physician are percented white private and private and private and private are private and private and private are private are private and private are private are private and private are private and private are private are private and private are private and private are	licai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or c.	as a consequence of): as a consequence of):	Ulm	entia					3 971
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 9 Unknown		2 ☐ Fetal death 3 t at time of death 5	□Ectopic pregna □ Other (specify					Date of deliveration	very Day Year
uires that signed b	þ	Part II. Other significant condition	ns contributing to deat	h but not resulting in the	underlying cause	given in Part I.		23e. Did t	~ /		the cause of death? bably 4 □Unknov
sician: The law requir certificate has been si lirector, page 2 should I	Completed						_	24a. Was autor perfo 1 ☐ Yes	an 24t osy rmed?	D. Were aut prior to o death? 1 \(\sum \text{Yes}	opsy findings availab ompletion of cause o
	BeC	25. Was case referred to medical examiner?				26. Place o	f Death (C		one)	``	
ding Physician: n. After this certifications of the director.	on: To	1 ☐ Yes 2 No 27. Manner of Death 1. Natural 5 ☐ Pendin	28a. Date of I	1inpatient 2 E-volupatient 3 DOA						(ty)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Certification:	2 Accident investig 3 Suicide 6 Could in 4 Homicide determine	not be 290 Place of	treet, factory, off	1 Yes 2 No		Location (nber or Ru	ral Route Number,	
To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	ical Ce	(Check only 2 Medical	Examiner: On the basis	est of my knowledge, dea s of examination and/or							
thin 2 or the or the or the or the	Med	one) 29b. Signature and title of certifier	and manner		29c. Lic	cense number			29d. Date sign	ned (Month	, Day, Year)
+ 3 F 8		1	Levelh	mi	2	3105	P		6-16	~ 06	
pr		30. Name and address of person Gene F. Ashe	who completed cause of	of death (Item 23a) (Type 10200 Cop	e, Print)			sboro.	MD 21		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 19 2006 June 3:02 pM Mabel Virginia Shaffer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death Examiner Carroll 490 Tremont Place Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr 01 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 13 PF Yrs. MD 215-26-7718 77 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a State 10h County ir then "netural", or Itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Carrol1 Westminster 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 490 Tremont Place Apt 2 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ White 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Interior Decorator Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be finent of Health and Mental I int: If Item 27 is marked o Ida Catherine Horning David Day Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 Westminster, MD 412 Washington Road R. Kyle Pritts, Jr/POA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6/26/2006 □ Burial 2 □ Cremation 3 □ Removal from State Department of Important: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans Cem Owings Mills, MD ne of Funeral Service Licens Pritts Funeral Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine inding physician and use as the burlal-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Yo

9 Unknown Month Year Day 5 Other (specify) 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 robably 4 Unknown 1 ☐ Yes 2 ☐ No been si Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 ER/Outpatient 7 1 Tyes 1 Inpatient 3 DOA 4 ☐ Nursing Home Sesidence 6 ☐ Other (Specify) 24 After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Matural 5 Pending м 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Trifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal Medic 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Georgetour Alord, Eldesburg 30. Name and address of completed cause of death (Item 23a) (Type, Print), 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11:15 1 - For State Registrat Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 June 12:30P M Clyde Spurlock /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 315 East "A" Street Brunswick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 15 5 Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 X M 2 ☐ F 68 Vre 1938 Jonesville, VA 212-36-3579 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ?7 le marked other then "natural", or Iteme 23a or 28a-f show traumatic event, the Modical Examinar must be notified at Frederick Brunswick 1 X Yes 2 ☐ No MD Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 315 East "A" Street 21716 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: if Item 27 le marked other then "natural", or Item eny Injury or other traumatic event, the Medical Exercises once. 1 ☐ Never Married 2X Married □Yes 2 XNo Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Clyde's Plumbing & Elementary/Secondary (0-12) College (1-4or 5+) Heating, Brunswick, MD 0wner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stella Gobble Caynor Newton Spurlock 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 East "A" Street, Brunswick, MD Rosa Lee Spurlock, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Park Heights Cemetery 6/15/06 Brunswick, MD 4 □Dofation 5 □ Other (Specify) 21. Signate of Full Account to the Barbara A. Willi 22. Name and Address of Facility
John T. Williams Funeral Home Owne Williams, 100 Petersville Road, Brunswick, MD 21716 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARCINOMA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Sequentiary list conditions, f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22No After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No 1 Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date sign (Month, Day, Year) 13/06 D 22037 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NINT AUT Brimail MD 21716 Kin 610 31. Date filed (Month, Day, Year) istrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 1 5 2006

		•	For State Registrar	State of M	1arylan				lealth a <i>Death</i>	nd Mer		ené () .	05	20557
	Dhysioir	an	Decedent's Name (First, Middle,	Last)							Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic	_	SALLY K. SHAI				41 07	-			June		006	1512 M
	Examin	er	4a. Facility Name (If not institution, Memorial Ho	SPITAL	r)			East	r Location of	r Death		4c. County	1601	-
	Funeral Director				ige (In yrs.	iast birthday) Yrs.	If Under Months		If Under 2 Hours	8. Min. J 1	Date of Birth		9. Birthp Cour	lace (State or Foreign
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	r 28a-	Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen of	What Cour	ntry?
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	teme	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	.S. 13.	Was Deced f Yes, spec	dent of H	lispanic Orig an, Mexican,	in? (Specify Puerto Rica	Yes or No- an, etc.)		ce - Americ ck, White,	
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e, P	1 and 2 Health am 27 ther tra		J. DOUGLAS SHAD 20a. Method of Disposition	RPE/SUN	20b. F	Place of Dispo			A 61.,	Date		Oc. Location	- City or To	own State
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Division of Vital Records, P.O.	ar dea ector by the	Certification:	3 Suicide 6 Could n	and 208. Place of I	njury - At ho	ome, farm, str	eet, factor	y, office		28f.	Location (Str. City or Town,		ber or Rura	l Route Number,
ā	itel or irs afte rei Dir led in													
	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	g Physicien: To the bes Exeminer: On the basis and manner	of examina	wledge, deat ition and/or in	h occurred vestigation	at the tir i, in my o	ne, date and pinion, deat	d place, and h occurred a	due to the ca at the time, da	use(s) and m te and place,	anner as s and due to	tated. the cause(s)
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		-	For State Registrar	State of Mar	yland / Dep <i>Ce</i>	artment of H	ealth and Death		giene.	06	20550
			1. Decedent's Name (First, Middle, Las	*				2. Date of Dea	ith Day	Year	3. Time of Death
	Physicia /Medic	Su	Ernest John Tho	omas), Day 2006		11:19p ^M
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	Funeral		5. Social Security Number 6. S 577-48-9370	ax 7. Age ((In yrs. last birthday, 67 Yrs.	Months Days		Min. 8. Date of Birtl (Month, Day 07/23/	1938	Counti	
	Director	-	Usual Residence of Decedent					017237	1330	wasn	., D.C.
	yland		10a. State 10b. County MD Montgon	1	10c. City, Town or L Bethesda					10	d. Inside City Limits
	Ba-f	cto	Monegon	ter y							1 ☐ Yes 2X No
	h with th	al Dire	10e. Street and Number 5108 Waukesha	Road		10f. Zip Code 20816			10g. Citizen of \	What Count	.y?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2√2 No If Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes XXNo		? (Specify Yes or No- uerto Rican, etc.)	Blac	ce - America ck, White, e v:Blac	tc.
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Baltimore,	Pages 1 ar		20a. Method of Disposition ★☆\$urial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		Ft. Place of Disp	osition (Name of Prator) of other place COLM CEN	n. 06	Date /15/2006	20c. Location - Bren	City or Tov	m, State d, MD
Balti	permit. Departn imports any inju		21. Sign yure of Funeral Service Licer	Mensey	01436 R	22. Name and Address Onald Ta 0583 Mic	ss of Facility Nation Idlepo	II Funer	al Cha hite F	pel Taln	s, MD
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	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 1 5 2006	32. Registrar	's Signature	e e	-				

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Ronald Lewis Ta		S I- For State Registrar	tate of Maryla		artment o e <i>rtificate o</i>		d Mental H	-	Reg. No.	200	5 3055	
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Funeral	┪	5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year		_	rth (MM/DD/YY		hplace (State or	
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with t	Funeral Director	13229 Bellevue	12. Was De	cedent Ever in		20904 as Decedent of His				ace - Americ	can Indian, Black,	
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121 d be fil ental F arked	Be	Rudolph Robert	Taddei				Dolores	Helena	ena Trov ute Number, Ci y or Town, State, Zip Code)			
Baltimore, MD 21215-0036 Separtin Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. I maper I frem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	ဥ	19a Informant's Name/Relation			- 4						Zip Code)	
and 2 sho and 2 sho fealth and item 27 is traumati		Randy Tadded 20a. Method of Disposition	/ Brother —	205	. Place of Dispo	East 4th sition (Name of cen		Date PA	20c. Locatio	n - City or	Town, State	
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Division To the Hospital or Attendi within 24 hours after death To the Funeral Director. Completely filled in by the fi	ical	(Check only Certifying	Physician; To the be xaminer: On the basis	est of my knowle s of examination	edge, death occu n and/or investiga	urred at the time, da ation, in my opinion	ate and place, an i, death occurred	d due to the cau at the time, date	ise(s) and man e and place, an	ner as started d due to the	ed e cause(s)	
To T	Medical	29b. Signature and title of parti	and manner	stated.		29c. Licens					nth, Day, Year)	
			MA.	1/		O.C.I	M.E.		June 23,	2006		
,		30. Name and address of person							1			
/			eputy Chief Med			nn Street, Balt	timore, MD 2	1201				
St Regis	tate trar	31. Date filed (MoJUNy, Yegr) 6 2006 32. 9 Signature										
1 regis	14.51			On the second								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** June 8, 2006 1:15 AM Caroline Baumbach Turecamo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

April 26, 1912 New York 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2XXF Months 94 109-07-7816 Director Usuaf Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ir than "natural", or items 23a or 28e-f show the Medical Expenies west be notified at 1 X Yes 2 No Director Anne Arundel Crofton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21114 2131 Davidsonville Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XXNo ff Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other treumatic event, Item Metales. Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ff Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Caroline Scholle Francis Baumbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1677 Tarleton Way Crofton, MD 21114 Diane Turecamo Carey/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/12/2006 Bronx, New York 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 9LZHeimer's Physician YRS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physician and detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1☐Live birth 2☐Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown this certificete has been si ral director, pege 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No 1 Yes After this certification funeral director, r Hospitel or Attending Physician: 25. Was case referred to medical 26. Pface of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification; To 27. Manner of Death 28b. Time of fnjury 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 30. Name and a ldr ss of prison who completed cause of death (Item 23a) (Type, Print) STEINFELD 31. Date filed (Month, Day, Year) 32. egistrar's Signature State JUN 14 2006 Registrar

		•	For State Registrar	State of Mary	land / Depa	artment of	f Health and of Death		giene	06	205	51
1 %			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year	3. Time of D	Death
- N 3	Physici /Medic		LESLIE	Α.	TOTH			JUNE		2006	9:05	A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	n, or Location of De	ath		y of Dealh		
100	H 1 27.	7.	MAGNOLIA CENTE				NHAM			CE GE		
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Ye Months Da		in. (Month, Da	y, Year)	Coun		Foreign
	Director		Usual Residence of Decedent		83 Yrs.	<u> </u>		JULY 3	, 1922	HU	NGARY	
	and and	ŀ	10a. State 10b. County	100	c. City, Town or Lo	ocation				1	0d. Inside City	y Limits
	ied a	0	MD. PRINCE G	FORGES		HYATTSV	TLLE				TX Yes	2 🔲 No
	the 28a	Director	10e. Street and Number	LONGLE		10f. Zip Cod			10g. Citizen of	What Coun	ntry?	
	3a or	ā	5612 DECATUR	PT.			20781		I	.s.A.		
	death ms 2	Funerai		12. Was Decedent Ever	in U.S. 13.	Was Decedent	of Hispanic Origin?	(Specify Yes or No	14. Ra	ce - Americ	an Indian,	
9	or He		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give			cuban, Mexican, Pu No Specify:	erto Rican, etc.)		ick, White,	etc.	
ğ	rel', c	by	3 X Widowed 4 □ Divorced	Year or Dates:		1 □ Yes 21💢 I	чо зреспу:		Speci	y: WHI	TE	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f ehow Te Medical Examinat must be notified at	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Oc kind of work do	ne during most of v	vorking	16b. Kind of E	Business/Ind	dustry	
2	afbin Por	idu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re			DIVO	mo on t	~~~~	
7	filed w Hygier other ti		17. Father's Name (First, Middle, Last)	2		PHOTOG	RAPHER	Inma /Fina Adidala		TOGRA	PHY	
our our	be fi	Be		m o m			To. Mother S I	lame (First, Middle,				
Ž	should ind Men ind marke	²	JANOS 19a, Informant's Name/Relationship (Ty	TOTH	10h Maili	ng Addrose /Ste	net and Number or	JOLAN Rural Route Numbe		RAMAT		
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ė,	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan ortainent of Health and Mental Hygiene. ortainert if item 27 le marked other then "naturel; or Itema 23a or 28a-f ehow injury or other treumatic event, it a Medical Examination at the robified at a.		PETER L. TOTH/SO 20a. Method of Disposition		0b. Place of Dispo	sition (Name of		ERWYN HEI	20c. Location			
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Division	or Attendated after death Director:	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, larm, st	reet, factory, offi	се	28f. Location (S City or Tow		ber or Rura	l Route Numb	ier,
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	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	dical	29a. Certifier (Check only one) 1 X Certifying Physical Examinates Company 2 Medical Examinates Medical Examinates Company (Check only one)	sician: To the best of moner: On the basis of exa and manner stated.	y knowledge, deat imination and/or in	h occurred at the evestigation, in n	e time, date and pla ny opinion, death o	ace, and due to the occurred at the time,	cause(s) and m date and place	anner as st , and due to	ated. the cause(s)	
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	•	1	30. Name and address of person who co					300	10			
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	/Medic		Ernest C.	Trimble						ine 1	6 2006		48 P M
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	D		Usual Residence of Decedent										
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	8a-f	Director	Maryland Baltimo	re	Lu		ville				022		
	with t	급	10e. Street and Number	No. 4		10t. Zi	Code	0.2			J. Citizen of What	-	
	eath	eral	316 Merrie Hunt I	JEIVE 12. Was Decedent Ever in U	S. 13.3	Was Dece	210		n? (Specify		Jnited St		
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Maryland	d be findal h	Be C	Ernest Trimble						ry My		noon oumanie)		
2	shoulk od Me mark matik	ဥ	19a. Informant's Name/Relationship (7)	/pe, Print)	19b. Mailir	ng Addres	s (Street ar				City or Town, State	, Zip Coo	te)
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ē,	s 1 al		20a. Method of Disposition	20b. F	Place of Dispo				Date		c. Location - City		
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	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect of the conse	quence of):								aval Between set and Death
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			Daniel 0	Conde	Mo		DO	281			6/17	06	
1			30. Name and address of person who o								· · · · · · · · · · · · · · · · · · ·		
2			DANIEL ALEXANDER N			EONAR	DTOWN	, MD	20650				
	St. Regist	ate rar	31. Date filed (Month, Day, Year) JUN 2 0	32. Regitrar's Sign.	ature	A.	4 .						

ERNEST C. TRIMBLE

State of Maryland / Department of Health and Mental Hygiene 7006 29563 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Month **Physician** Etta Marie Uwadi June 13, 3:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 2\ F 68 Director 579-54-9925 May 25, 1938 Washington, DC. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits al Hygiene, citier then "neturel", or iteme 23a or 28a-f ehow vent, the Madical Exeminer must be notified at 1 X Yes 2 No Director Maryland | Prince George Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20784 United States 5005 70th Place death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Aide Medical 12th 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental Lessie Bell John Wesley Spearmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2:
Department of Health at
Important: If Item 27 ie
eny injury or other trau 11310 Kettering Way; Upper Marlboro, MD. Valencia Martin/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cemetery June 21,2006 4 □ Donation 5 □ Other (Specify) Brentwood, MD 22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike Forestville, Md. 21. Signature of Funeral-S 23a. Part 1. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) THROMBOCY PROFOUND **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. LOMA Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2) CORD HAILY ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown TENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No VAGINAL BLEFDING 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ his 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury s effer dea... al Director: Afr 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D2456 3331 -HYAT 30. Name and address of person who complete

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

JUN 1 6 2006

State of Maryland / Department of Health and Mental Hygiene 10 6

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			For State Registrar	State of Maryla		tificate of L			. No.	, 2000%
	F 2		Decedent's Name (First, Middle, Last	0				2. Date of Death Month	Day Yea	3. Time of Death
	Physicia /Medic		Arnold	F.	Utesch			June	8 2006	7:05 p ^M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of De	
		\$	Anne Arundel Med			Annapol				rundel
S	Funeral Director		480-24-8317	7. Age (In y. ŽM 2□F 78	rs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,) Aug. 12	(ear) 9. E	Birthplace (State or Foreign Country) OWA
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Marylan f show	ō	MD Anne Aru	ınde1	Annapo	lie				Yes 2 No
	7 28a	rec	10e. Street and Number		IIIIIapo	10f. Zip Code		100	. Citizen of What	Country?
	h with	a D	615 Admiral Drive	غ		214	01		USA	
	within 72 hours after death with the Maryland ene. than 'naturel', or Items 23e or 28e-f show he Madical Exemirer must be intillied at	Funeral Director	11. Marital Status 1 □ Never Married 2004Married	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spec n, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
21215-0036	ours aft	by	3 Widowed 4 Divorced	1∑Yes 2 □ No If Yes, Give Year or Dates: 194	47-55	1□Yes 2 XX No	Specify:		Specify:	White
5-0	72 hc	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give		luring most of workin	9 16	b. Kind of Busine	ss/Industry
121	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "rearmatic event, the Mad	mp	Elementary/Secondary (0-12)	College (1-4 <i>o</i> r 5+)	Sales	DO NOT use retired,)		Industri	al Meats
	Hygie ther t nt, to		17. Father's Name (First, Middle, Last)		Sales		18. Mother's Name	(First, Middle, Ma		ar nears
Maryland	d be 1	To Be	William F. Utesch	n			Bertha	Gardner		
<u> </u>	shouls nd Me mark	ř	19a. Informant's Name/Relationship (T		19b. Mailii	ng Address (Street a	and Number or Rural			e, Zip Code)
M	nd 2 :		June Y. Utesch (V	Wife)	615	Admiral D	rive, Ann	apolis,	MD 21401	
re,	of Hez item othe		20a. Method of Disposition	201	b. Place of Dispo	sition (Name of matory or other place	Di	ate 20	c. Location - City	or Town, State
Ē	Page ment c		1 ☐ Burial 2 【 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	mellioval iloiti State	Metro Cr		6-12-	2006 I	Baltimore	, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. important: if item 27 is marked other than "naturel", or Items 23s or 28s-1 show enty injury or other traumatic event, the Medical Exeminar must be multiple a once.		21. Signature of Funeral Service Licen	J-	22		s of Facility Funeral Ly Avenue			21401
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	dications that caused the done cause on each line.	eath. Do not ent					Approximate Interval Between
	Pnysician	3	Immediate Cause (Final disease or condition	. Cil						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons						
	LXdiffiller	L	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	con of					20 yr
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	tificate be executed ng physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or its a cons		200				1
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	tificat ig phy as th	Medical	-							
P.O. Box	ath cer attendir for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	w requires that the deben signed by the should be detached	ьу Р	Part II. Other significant conditions co	ontributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
rds	equires sen sign ould be	ed b						1 🗆 Yes	20 No 3□	Probably 4 Unknown
Records,	e tar has	Completed						24a. Was an autopsy performe	prior	
Division of Vital	Physicien: Th r this certificate ral director, pag	BeC	25. Was case referred to medical examiner?				26. Place of Death			
× ×	Physicien: this certific ral director,	2	1 ☐ Yes 2 ☐ No		2 ER/Outpatier		4 Nuising Hon		ce 6 ☐Other (S	pecify)
n	aft e	ion:	27. Manner of Death 1 Satural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	r) 28b. Time o	Work	c ?	8d. Describe how	rinjury occurred	
Sic	ttend death stor: /	Icat	2 Accident investigation 3 □ Suicide 6 □ Could not be		At home farm et		Yes 2□No	8f. Location (Stre	et and Number or	Rural Route Number,
Div	afor A after Direct d in by	Certification:	4 Homicide determined	building, etc. (Sp.	ecify)	reet, factory, office		City or Town,		ridiai ribato (varibor,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai C	29a. Certifier Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the time exestigation, in my op	ne, date and place, a pinion, death occurre	nd due to the cau	se(s) and manner e and place, and	as stated. due to the cause(s)
	To th Mithin To the	Me	29b. Signature an⊅ (Ittle of c∞ fier	M		29c. License		29	d. Date signed (Mo	onth, Day, Year)
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			30. Name and address of person who		Item 23a) (Type,	Print)	1	. 4		2006 mo 2140/
			1.//	ATKINS I	12	900 sp.)TGATE 1	o par	197010	NO 51401
Š	Sta Regist		31. Date filed (Month Day, Year)	006 337 egistrar's Si	ignature	and I				

State of Maryland / Department of Health and Mental Hygiene COCUS Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9:40 AM June 11, 2006 Elizabeth Varner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 33 Dr. Carr Drive North East Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) West Virginia 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🔀 F 234-64-1513 85 Yrs November Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 27 is marked other than "natural", or itams 23a or 28a-f show traumatic evant, the Medical Experiment mastice notified at 1 ☐ Yes 2 1 No Maryland Cecil North East Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 33 Dr. Carr Drive 21901 United Statea death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Education Cook 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill iment of Health and Mental H tant: If Item 27 is marked ott Isaac Wilson Moore Minnie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Minnie O. McDilda 1920 Old Elk Neck Road Elkton, Maryland 21921 other 2006 Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) June 14. 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 0 permit. Page Department of important: if any injury or once. North East Methodist North East, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ailure disease or condition resulting in death) /Medical Due to (or as a consequence of) Engestive Heart Failure Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown certificate has been signed irector, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 2 10 24a. Was an autopsy performed 20X No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be 1 ☐ Yes PNo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 6 esidence 6 Other (Specify) 2 this 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manper of Death 28d. Describe how injury occurred After Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 3 🗀 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical within 2 To the 29d. Date sigged (Month, Day, Year) 29c. License number 29b. Signature and title 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rising Sun, MD Main 10 Khadar 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 2006 5:15 a Chih Ming Woo June 10, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Independence Court Assisted Living Hyattsville Prince George's Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Months 93 June 17, 1912 Director 113-20-1997 China Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or than "natural", or Items 23a or 28e-f show the Medical Examinar must be notified at 1 X Yes 2 No Director Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? death with 4410 Oglethorpe Street 20781 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Examinations. Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Chinese 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5 Restaurant Co-Owner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Jing-Wi Woo 2 Li Shi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucrecia Rozo Woo - Wife 4410 Oglethorpe Street, Hyattsville, No 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Fairfax Memorial Park 06/15/06 Fairfax, Virginia 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue, Hyattsville, MD 20781 Munn 23a Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Prostate Cancer /Medical Due to (or as a consequence of) Examiner Systemic Hypertension Sequentially list conditions, nary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physician and s the burial-transit Coronary Artery Disease Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Hoknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 ☐ No 1 Yes 2 X No Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Steven Tee

Registrar

State

3415 Hamilton Street

31. Date filed (Month, Day, Year)

JUN 1 4 2006

Maryland 20782

#1, Hyattsville,

32. Registrar's Stgnatur

		•	For State Registrar	State of Maryland	d / Depa <i>Cer</i>	rtment of Healti tificate of Dea	n and Mental H th	ygiene) (6 20061
		_	Decedent's Name (First, Middle, Last	t)			2. Date of D	Death	3. Time of Death
	Physicia /Medic		MABLE LEAN	WOOTEN				8,2006	2:40R M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or Location	on of Death	4c. County of	Death
			Prince George H			Cheverly	dos Os Uso	P.G.	
	Funeral Director		5. Social Security Number 6. S 2 4 4 - 4 8 - 5 6 9 0	7. Age (In yrs. la	Yrs.	If Under 1 Year If Under 1 Months Days Hou	der 24 Hrs. 8. Date of B rs Min. (Month, L Feb. 2	Birth Day, Year) 21, 1937 N	3. Birthplace (State or Foreign Country) . Carolina
	pur *	-	Usual Residence of Decedent 10a, State 10b, County	10c City	, Town or Lo	cation			10d. Inside City Limits
	daryla aho	5	D.C.		ringt				1 ∑Yes 2 □ No
	28a-	ect	10e. Street and Number	0000		10f, Zip Code		10g. Citizen of Wh	at Country?
	ath with	ral Di	5048 Hanna Plac			20019		U.S.A.	
21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exercipat must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 □ No If Yes, Give X Year or Dates:		Vas Decedent of Hispanic f Yes, specify Cuban, Mex		Black,	American Indian, White, etc. Black
Q Q	72 ho	ted	15. Decedent's Ed (Specify only highest gra		16a. Deced	lent's Usual Occupation	nost of working	16b. Kind of Busi	
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	led w lygier her th	ပိ	8 th 17. Father's Name (First, Middle, Last)		Dome	stic Worke	いた。 Other's Name (First, Middle	Maryla.	
auc	I be fi	Be o	Willie Nobles				lie Nobles	io, ivialuoti Sutriarile)	
Maryland	thoutend Me	은	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin		mber or Rural Route Num	nber. City or Town. St	ate. Zip Code)
Ma	nd 2 s lith an 27 is r trau		Lillie R. Haggi	· ·	1615	Shamrock	Ave Capita	ol HGTS,	md20743
Baltimore,	Pages 1 ar nent of Hea nt: If item iry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specification)	Removal from State	ace of Dispo emetery, crem CINTLO	sition (Name of natory or other place) C NULLONUL	Date 6-19-2006	20c. Location - C. Quantic	ity or Town, State o , $V\alpha$.
Balti	permit. Departminports Imports any inju		21. Signature of Funeral Service Licer	see Andrews		Name and Address of Fa	s 5635 Ead	s St, N. ε	
			23a. Part 1. Enter the disease, or com	plications that caused the death	. Do not ent	er the mode of dying, such	as cardiac or respiratory	arrest,	Approximate Interval Between
	Physician :		Immediate Cause (Final disease or condition	Hem	1	8-00	holon	THE.	Onset and Death
	/Medical		resulting in death)	Due to (or as a consect	ence of):	1	0.14	4.7	
	Examiner		Sequentially list conditions,	b. Vontr	zen	las Fe	brillat	ion	
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	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of);	Jo)			
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.O. Box	at the death certifi by the attending priached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)		23d. Date Monti	,
s, P	ss tha	by	Part II. Other significant conditions of	ontributing to death but not resu	ilting in the u	nderlying cause given in Pa		100	ute to the cause of death?
orc	w require been si	eted						1.3	
al Records,	The ate h page	Completed						topsy pri rform ęd /? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No
Vital	Physician: Th this certificate al director, paç	Be	25. Was case referred to medical examiner?	Hospital:		Other	lace of Death (Check only		-
oţ		. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Cate of Injury	ER/Outpatier 28b. Time of	IL 3 DOA 4L	Nursing Home 5 Re 28d. Describe	sidence 6 ∐Other e how injury occurred	
	ding I h. After funer	tlon	1 Natural 5 Pending 2 Accident investigatio	(Month, Day Year)	Injury	28c. Injury at Work? M 1 \(\sum \) Yes 2		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division	Attending r death.	flca	3 Suicide 6 Could not b	e 28e. Place of Injury - At ho	me, farm, str	eet, factory, office			or Rural Route Number,
Ö	tal or Attendii s after death. al Director: A ed in by the fu	Certification;	4 Homicide	building, etc. (Specify	,		City of 1	own, State)	
	To the Hospital or Attuining 24 hours after de To the Funeral Directorompletely filled in by the	Medical (nysician: To the best of my knowniner: On the basis of examinat and manner stated.					
	vithin 2 To the	Me	29b. Signature and title of certifier	A		29c. License numb	per DF1G	29d. Date signed	Month, Day, Year)
0	(2)		30. Name and address of person who	completed cause of death (Item	23a) (Type.	Print)	2/5	9	6
_	19		31. Date filed (Month, Day, Year)	100 is 3001	1 110	spital Di	R Chevir	ly mo	20785
	Sta Registi		JUN 1 3 2006	2. Registrar's Signal	Spen	E)			

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	5	- For State Critificate of Death Legistrar	Reg	, No. 20	36 2006
Physician Medical Examine	1/	Joseph Lee White	2. Oate of Death Month June 9, 200	Oay Year	3 Time of Death 1417 hrs
wedical Examine		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Oeath		4c. County of Oea	
		330 Brockton Road Oxon Hill		Prince Georg	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 214-68-9013 1 XM 2 F 50 Yrs. Months Oays Hours Min.	. 8. Oate of Birth	(MM/00/YYYY) 9. E	eign Wash.
	L	2 1 4 - 68 - 90 1 3 1 XM 2 F 50 Yrs. Usual Residence of Decedent			Country) D.C.
v any	- 1	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show any d at once.	ទ្ធ	MarylandPrince George Oxon Hill 10e. Street and Number 10f. Zip Code	T10/	Citizen of What Co	1 Yes 2 X No
5-0036 led within 72 hours after death with the Maryland dyglene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once the medical Examiner must be not provided by the Examiner must be not provided by the medical Examiner must be not provided by the medical Examiner must be not provided by the must be not provided by the medical Examiner must be not provided by the medical Examiner must be not provided by the must be not	Director	10c. Street and Number 10f. Zip Code 20745	100	USA	uritry /
with the as 23a penoti		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.			erican Indian, Black,
or iten	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Oivorced If Yes, Give Year 1 Yes 2 X No 1 Yes 2 X No	Rican, etc.)	White, etc.	hite
ural",	⋧┞	15. Oecedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v		Specify: ** 16b Kind of Busines	
72 hou n "nat al Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	red)	None	
5-0036 led within 72 Hygiene. other than '	티	10th Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name	/Eiret Middle Mr		
21215-0036 uld be filed within 7 Mental Hygiene. Marked other than e event, the Medica	Se	Harry J. White, Jr. Mary Am	nelia M	ullen	
212 hould be ad Men is mark		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F			
e, MD I and 2 sho Health and item 27 is	-	Thomas White/Brother 6905 Cedar Crest 20a Method of Disposition 20b. Place of Disposition (Name of cemetery.		20c. Location - City	
늘 ~ 등 드림		1 X Burial 2 Cremation 3 Removal from State Nat. Mem. Park 6/1	15/06		hurch, VA.
Baltimo permit Page Department of Important: injury or oth	1	4 Donation 5 Other Specify: 21. Manual of Funeral Service Licensee 22. Name and Address of Facility Ge	eo. P.	Kalas Fu	neral Home
	1	Syr P. Kales 1. 6160 Oxon Hill	Rd. Ox	on Hill,	
Physician /Medical		23a. Part I. Enter the disease, or compiled ions that caused the death. Oo not enter the mode of dying, such as cardiac of failure. List only one cause on each ine.	r respiratory arres	st, snock, or neart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a Multiple Gunshot Wounds Due to (or as a consequence of):			
	اي	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause			1
cecuted and transit	E E	events resulting in death) Last Due to (or as a consequence of): d.			
. s a a	Medical	UNPENDED AMENDED			
		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delive	
Box 687; death certification be attending and for use as t	sician	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	aricy	Month	Oay Year
Bo he deat the at hed for	Phys	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e Did tob	acco use contribute	to the cause of death?
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the ris after death. The law rectificate has been signed by all Director: After this certificate has been signed by the fineral director, page 2 should be deated.	≦	Part is. Other significant conditions — contributing to death but not resulting in the underlying cause given in Part i			robably 4 Unknown
ords, ** require s been si should b	eted	W	24a Was ai		autopsy findings available o completion of cause of
ecol he law te has age 2 sh	Completed		perform	ned? death'	?
Vital Rec	Be C	25. Was case referred to medical examiner?	only one)		
F Vit	2	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		Residence 6 V Oth	ner: Scene
on of \nding Phylading Phy	tion:	1 Natural 5 Pending FOWND: Day, Year) FOUND: 1 Yes 2 V No	Subject shot	on injury coodinou	
ViSic or Atte fter des Sirecto in by th	ertification:	2 Accident Investigation Jun 9, 2006 1410 hrs 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (St or Town, Sta		Rural Route Number, City
Diversal Internal I	Cert	4 V Homicide determined (Specify) Single Family	330 Brockton	Road, Oxon H	
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certification of the theory after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basic of #xamination and/or investigation, in my opinion, death occurred a death occurred and one)			
To with To com	Med	29b. Signature and title of pertifier 29c. License number		29d. Date signed (A	fonth, Day, Year)
		O.C.M.E.		June 10, 2006	
00 (5)		30. Name and address of person who complete cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201		
Sta	ate		201		
Registr		31. Date filed (Month, Day, Year) 2. Registrar's Signature 3. 2006	_		

OHMH 17 Rev 1/2001 OCME 2006

		1	For State Registrar	State of M	aryland / Depa	artment			and M	lental Hy	gier Reg. 1	- C U U	D	20559	
Fig.	***	_	Decedent's Name (First, Middle, L							2. Date of De		Day \	'ear	3. Time of Death	
	Physicia /Medic	al -	James Odess		White					June	-	2006		6:30 a M	
	Examin	er	sa. Fecility Name (If not institution, g Magnolia Garden		4b. City, Town, or Location of Death Lanham					4c. County of Death					
	Funeral		5. Social Security Number 6.		je (In yrs. last birthday)	tf Under		If Under	24 Hrs. Min.	8. Date of Bir (Month, Di	rth	ar) (9. Birthp	otace (State or Foreign	
	Director	_	579-42-3388	1□M 2⊠F	83 Yrs.	Months	Days	Hours	MIN.	05-19-	192	23 1	lewb	ern, N.C.	
	pur *	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				-			1	Od. tnside City Limits	
	Maryla f sho	ŏ	Maryland P.G.		Glenard	len								¥ Yes 2 □ No	
	r 286	rec	10e. Street and Number		l	10f. Zip	Code				10g.	Citizen of Wh	at Cour	ntry?	
	th with	Funeral Director	7912 Grant Drive				2070)6			U	J.S.A.			
	ems	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Deced	ent of Hi	ispanic Origin, Mexican	gin? (Spo , Puerto	ecify Yes or No Rican, etc.)	0-		Americ White,	can tndian, etc.	
36	72 hours after death with the Maryland natural', or Items 23a or 28e-1 show disal Examinat must be mollified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X tf Yes, Give Year or Dates:	No	1 ☐ Yes	X No	Specify:				Specify:	B1a	ck	
21215-0036	2 hour	ted	15. Decedent's	Education	16a. Dece	dent's Usua	l Occupa	ation			16b	. Kind of Busi	ness/In	dustry	
215	thin 7.	Completed	(Specify only highest (Elementary/Secondary (0-12)	College (1-4or	5+)	kind of wor DO NOT us			OF WORK	ing					
	led wi		17. Father's Name (First, Middle, La	4	Regi	stere	d Nu		r'e Name	e (First, Middle				1 Hospital	
Maryland	d be find the control of the control) Be	James Butler	31/						nichael		ion Juniame,	,		
Z Z	should nd Me mark matic	2	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address	(Street a			al Route Numb		ty or Town, S	tate, Zip	Code)	
	and 2 eith a 127 is		Sylvia Johnson/	daughter	Upper	Marı	Dorc	, Mar	cyla:	nd, 207	72				
Baltimore,	of He of He fiter		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	□Removal from State	20b. Place of Disp cemetery, cre					Date		. Location - C			
Ë	Pag tment tent: I		' 4 □ Donation 5 □ Other (Spe	cify)	Harmony	Memor	ial	Park	06-	13-2006			-	aryland e, Inc.	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene Importent: if item 27 is marked other than "natural", or liems 23a or 28e-1 show any njury or other traumatic avent, the Medical Examinating must be notified at OREs.		21. Signature of Funeral Service Lie	Bacon										c. 20010	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	ly one cause on each I	ine.			-						Approximate Interval Between Onset and Death	
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Candio Valsandon Distant								years				
										Yenn					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):								James		
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									4		
8760,	certificate be executed trding physicien and use as the burial-transit	ai Ey	resulting in deathy East	Due to (or as	s a consequence of):										
687	ficate physics the l	edicai		d											
Box (leath certifica attending ph I for use as th	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□Ectopic pr	oonanov	,				23d. Date			
	e death the atten	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown									Month Day Year			
P.0	res that the de signed by the a l be detached t	Ph)	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying c	ause giv	en in Part I		23e. Did	tobacc	bacco use contribute to the cause of death?			
ecords,	equires sen sign ould be	d by							1 🗀	Yes	2. No 3 Probably 4 Unknown				
S	- 9 G	Completed								24a. Wa		24b. W	ere auto	opsy findings available omptetion of cause of	
$\mathbf{\alpha}$	The lav ate has page 2	mo								peri	opsy ormed 2 Q	? de	ath?	2 ☐ No	
ital	ysicien: Th is certificate director, pag	Be C								h (Check only					
of V	Physicien: this certific ral director,	ဠ	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								(y)				
Division of Vital	Jing Alter fune	tion:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28b. Time of Injury Work? 4 Describe							now ii	ow injury occurred				
/isi	Attending r death. setor: Alter by the fune	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Ptace of Ir	ntury - At home, farm, s	treet, factor							or Rura	al Route Number,	
ā	s afte	Certification:	4 Homicide	building, e	tc. (Specify)					City or To	JWII, S	iale/			
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical		Physician: To the bes kaminer: On the basis and manner s	of examination and/or i										
	within To the	Me	29b. Signature and title of certifier	. 1	^	290	-	e number				Date signed		Day, Year)	
			1/Kake	8h ar	019		D	20	10	8	-	6/12	10	6	
1/2	- (10)	30. Name and address of person who completed cause of death (them 23a) (Type. Print) Rakesh Arora, M.D. 14300 Gallant Fox Lane Suite 222 Bowie, Maryland, 207									d, 20715				
	Sta Regist		31. Date filed (Month, Day, Year) JUN 1 6 201	16 Alexander	trar's Signature	w									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 12:42₽[™] **Physician** June 12, 2006 WALKER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Gaithersburg Montgomery Shady Grove Hospital | FUnder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State of Country) | Sept. 26,1938 | Brooklyn, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1⊠M 2□ F 67 105-30-2035 Director Usual Residence of Decedent 10d, Inside City Limits Maryland 10c. City. Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "netural", or items 23a or 28a-f shot treumstic event, the Mudical Examiner must be notified at 1 Yes 2 No Director Silver Spring Md. Montgomery the 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Heelih and Mental Hygiene. Important: if Item 27 is marked other than "netural", or Items 23a or 2 any Injury or other freumatic event, the Madical Examinat must be a page. 20901 U.S.A. 11122 Oak Leaf Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☑ No Specify Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government Machinist 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Grace Jackson Horace Walker Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11122 Oak Leaf Drive, Silver Spring, Md. 20901 Russell Walker/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 6/19/06 Cheltenham, Md. Md. Veterans Cem 22. Name and Address of Facility Johnson & Jenkins Inc. 21. Signature of Prineral Service Licensee 716 Kennedy St., N.W. WDC 20011 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myocardial Inforction Immediate Cause (Final disease or condition resulting in death) nours a carte **Physician** /Medical Due to (or as a consequence of) disease Examiner æ OFONO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificete has perform 1 Yes 2 No 1 ☐ Yes 2 X No To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ Coutpatient 1 ☐ Yes 2 No 3□ DOA ပ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After t Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined filled in by 4 - Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely Within 2 29d. Date signed (Month, Day, Year) 29b. Signature and Title of Pertifier U0051927 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive Rockville, MD. 20850 Dawn Thornton, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 1 6 2006

State of Maryland / Department of Health and Mental Hygiene 055 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day June 13, 2006 **Physician** Charles Edward Wray 15:04 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral 1⊠M 2□ F Director 230-42-1080 Mar 20. 1933 Virginia Usual Residence of Decedent Manyland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Peges 1 and 2 should be filed within 72 hours after death with the Marylar ment of Heelih and Mental Hygiene.
and: If fend it is marked other than "natural; or iteme 23a or 28a-f show ury or other traumatic event, the Madical Examine must be notified at 1X Yes 2 □ No Maryland Prince George's Hyattsville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20782 U.S.A. 5608 29th Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2 No Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker J.S. Wagner Unavailable 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edgar Wray Katherine (Unknown) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5608 29th Avenue, Hyattsville, MD 20782 Joyce M.V. Wray - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Depertment of Important: If any injury or once. Maryland National Cemetery 6/17/06 4 □Donation 5 □ Other (Specify) Laurel, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Furieral Service License. ay 4739 Baltimore Avenue, Hyattsville, MD 23a. Partl. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one call use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ke ly anth Metastos mate Physician Hdeno Carcinon disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially 1st can Nons if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, s been signe should be o 1. Yes 2 □ No 3 □ Probably 4 □ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2- No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 No Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 Tes 2 No investigation hours after death. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 | Homicide Pelli To the Hospital within 24 hours To the Funarai 29a, Certifie f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) te of certifie 29b. Signature and D45660 CN, 124 BULIS MD 20 2K D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GALLANTFEX 14300, 31. Date filed (Month, Day, Year) State IUN 1 6 2006 Registrar

		•	For State Registrar	State of Maryla			of Health a of Death	and Me		giene No. 2	Ù6	20572	
453	265		1. Decedent's Name (First, Middle, Las	t)				2	. Date of Dea Month	ith Day	Year	3. Time of Death	
	Physicia /Medic	_	JOHN H.	WHITING J	R.			ت	June	2, 200		6:44PM	
	Examin		4a. Facility Name (If not institution, give				wn, or Location o	of Death		4c. County			
			Southern Mary	land Hospi	tal		inton				ce G	eorges	
	Funeral		5. Social Security Number 6. S		rs. last birthda	/) If Under 1 Months [Year If Under a	Min. 8	. Date of Birth (Month, Day	3, 1933	Con	place (State or Foreign	
	Director		377-40-0023	-Xw 2 - /	2 Yrs.			IN	10V.28	3,1933	Vir	ginia	
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or	Location					1	Od. Inside City Limits	
	s 1 and 2 should be filed within 72 hours after death with fire maryland if Heelih and Mentel Hygiene. It Heelih and Mentel Hygiene. Item 27 is marked other then "natural", or itema 23s or 28s-f show other treumstic event, it a Medical Examinat must be notified at	Director		Georges	-	attsvi	lle					1 Yes 2 No	
			10e. Street and Number			10f. Zip C				10g. Citizen of V	What Cou	ntrv?	
			3829 Hamilton	St. #103			20781			U.S.		,	
		era	11. Marital Status	12. Was Decedent Ever in	n U.S. 13			gin? (Speci	fv Yes or No-			can Indian,	
	iten d	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No		If Yes, specify	nt of Hispanic Orig Cuban, Mexican	, Puerto Ri	can, etc.)	Blac	ck, White,		
36	irs af	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No Specify:			Specify	/: B	lack	
21215-0036	atura ea E	Completed by Funeral Director	15. Decedent's Ed		16a. Dec	edent's Usual (Occupation			16b. Kind of B	usiness/In	dustry	
7	nin 72		(Specify only highest gra	de completed) College (1-4or 5+)	life	. DO NOT use							
212	iene.		Elementary/Secondary (0-12)	5+	Mana	agemen	t Anayl	lst		D.C.	. Go	V •	
ğ	othe ent,	Bec	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name (First, Middle,	Maiden Suman	10)		
<u>a</u>	Aente de la	ToB	John H. W	hiting Sr.				F	Rosa	A. Uro	quha	rt	
Maryland	Shou nd M mar unat		19a. Informant's Name/Relationship (iling Address (Street and Number	er or Rural F	Route Numbe	r, City or Town,	State, Zip	Code)	
Σ	elith a		Samuel P.Whiti	ng Brother	450	09 Luj	ean Lar	ne,Ft	.Wash	1.MD.20	744		
Baltimore,	of Heelt item 2		20a. Method of Disposition		b. Place of Dis cemetery, ci	position (Name rematory or other	of er place)	Dat	te	20c. Location -	City or To	own, State	
Ë	Page nt: if ry or		Marial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specified)				n Cem J	June	9,06	Brent	woo	d,MD	
ati	permit. Pages 1 Department of H Important: If Ite any injury or ot 2002.		21. Signature of Funeral Service Licer	s96 4		22. Name and	Address of Facilit	dress of Facility Hunt Funeral Home					
ä	Depa impo any ir		primas to 1	time			nnedy S					11	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the c	leath. Do not e	nter the mode	of dying, such as	cardiac or i	respiratory ar	rest,		Approximate Interval Between	
	ate be executed // Medical Examiner and printing the printing transit		Immediate Cause (Final		Mylac	12 DIA	n INIT	-0-01-	TION			Onset and Death	
			Immediate Cause (Final disease or condition resulting in death) a. ACUTE MOCK DIAL INFARCTION Due to (or as a consequence of):								-		
			1		, , , , , , , , , , , , , , , , , , , ,								
		ě	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a con	зационсе оі).								
		Examiner	Cause (Disease or injury that initiated events										
Ć.	exec n an ial-tr	Exa	resulting in death) Last	Due to (or as a con	sequence of):								
8760,	e be sicie e bur	Ilcai		d									
68	tificat g phy as th	edi											
Вох	eath certific attending p	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy									23d. Date of delivery	
B	deatl	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of death 5☐ Other (specify)						Mo	Month Day Year		
P.0	at the de by the a	hys	9 🗆 Unknown	9L] Unknown									
4.	es that igned be be det	by P	Part II. Other significant conditions of			underlying cau	ise given in Part I	l.	23a. Did to	obacco use con	tribute to t	he cause of death?	
Ë	quire an sig		COKONAM!	HE TEISCHOUSE	DAGE				101	res 2□No	3 Prol	bably 4 ⊠Unknown	
00	Attending Physician: The law requires that the death certificate be executed refeath. releath. actor: Atter this certificate hes been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Completed	DIAGETES						24a. Was	an 24b.	Were auto	opsy findings available	
Re		E							rmed?				
Vital Records,		0	25. Was case referred to medical				26. Place	e of Death /	1 ☐ Yes Check only o		103		
>		To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
Division of			27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Describe how injury occurred									
		atio	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigatio		м								
Vis	Attendi	1100	3 Suicide 6 Could not be determined	286. Place of injury - At nome, farm, street, factory, office					28f. Location (Street and Number or Rural Route Number,				
Ö	al or s effe t Dir	Certification	4 Ditamolos	building, etc. (3)	building, etc. (Specify) City or Town, State)								
	hour hour unera			nysicien: To the best of my									
	To the Hospital or Attent within 24 hours efter deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Example)	niner: On the basis of examend manner stated.	milation and/of	iiivestigation, i	ii iny opinion, dea	aut occurred	at the time,	uate and place,	anu due t	o me cause(s)	
	To t withi To tl	Σ	29b. Signature and title of confiner			1	License number	i		29d. Date signe			
			1. 200, 216			3) 4032°	4	The state of the s	JUNE 3	5, 3	OCE	
Λ	1		30. Name and address of person who	completed cause of death	(Item 23a) (Typ	oe, Print)		1	2 0	144 A 2		17	
IL	15/		TEREN JOUR 12)	M.D. 7503	SUR2 F	9 175 2	DAD, C4	NIN	MAR	-YLAVO	00	731	
7		ate	31. Date filed (Month, Day, Year)	2. Registrar's S	Signature								
	Regist	rar	JUN 1 5 200	6 Registrar's S	5 AD								

		4	For State Registrar	State of Mary	Cer	tificate of	Death		Reg. No.	19212
	Physici	an	Decedent's Name (First, Middle, La	•				2. Date of Dea	Day Yeer	3. Time of Death
	/Medic	al -	LUELLA 4a. Facility Name (If not institution, giv	WHRE	N	4b. City. Town, o	r Location of Dea	JUNE .	10 2006 4c. County of Dea	
	Examin	ier	SUBURBAN HOSP			BETHE			MONTGOME	RY
ı	Funeral		5. Social Security Number 6. S	Sex 7. Age (Ir	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr		th 9. Bir	thplace (State or Foreign
C	Director		578-68-9196 Usual Residence of Decedent	1 C M 2 X F	55 Yrs.			DEC. 3	, 1950FT.	MOTTE, SC
and	À =		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
Mary		ţ	DC		WASHIN	GTON				1⊠Yes 2□No
h the	288	irec	10e. Street and Number		71220220	10f. Zip Code			10g. Citizen of What C	ountry?
death with the Maryland	23a	alD	354 ANACOSTI				0019		UNITED	
OUSO hours after dea	lal Hygiene. d other than "natural", or itams 23a or 28a-f show evant, the Medical Exchnitise must be natified at	by Funeral Director	11. Marital Status 1 ▼Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2⁄2 No		Specify Yes or No ino Rican, etc.)	14. Race - Am- Black, Whi Specify: BI	te, etc.
5 P	ical E	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	oation	orkina	16b. Kind of Business	/Industry
within 72	Mad "	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	UKING		
N D	lygien her th		12th 17. Father's Name (First, Middle, Last	0			COOK	ama (First Middle	RESTAURA	ANT
and d be file	od ot	Be	EDWARD WHREN				MATI		RTLEY	
<u> </u>	mark matic	ဥ	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street	<u> </u>		er, City or Town, State,	Zip Code)
Ma nd 2 s	f Heelth and M Item 27 is mer other traumat		SHAUNTE SPRUIL		1140	3 VEGA	COURT	UPPER M	ARLBORO,	MD 20774
s ta	item item		20a. Method of Disposition	1	20b. Place of Dispo		- 1	Date	20c. Location - City or	
Pages	ment of tant: if it		1 Burial 2 Cremation 3 € 4 Donation 5 Other (Speci						SUITLAND	
	Departr Importa any inja once.		21. Signature of Funeral Service Lice	Lake on	- Jall	2. Name and Address			APITOL MO	. D.C.2000
			23a. Parl 1. Enter the disease, or conships ck, or heart failure. List on	plications that caused the one cause on each line.	death Do not ent	mode of dyi	ng, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	ysiciali		Immediate Cause (Final disease or condition	. Se	PSIS	<i>'</i>				unkwon
	Medical kaminer		resulting in death)	Due to (or as a 6	onsequence of):					
	,	ē	Sequentially list conditions,	b. Due to (or as a c	onsequance of).					
petn	dansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C						
O,	en an rial-tr		resulting in death) Last	Due to (or as a co	onsequence of):					1
68/60, iticate be executed	physicien and the burial-transit	edicai		d		·				
	On 66		IF FEMALE:	22a If was automa of a			-			
Records, P.O. BOX The law requires that the death cer	been signed by the ettending should be detached for use a	by Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	☐Ectopic pregnanc☐ Other (specify) _	ry .		23d. Date of de Month	Day Year
P.O.	y the	ysi	1 U Yes 2 No 9 Unknown	9☐ Unknown						
s that	ned b e deta	y P	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	inderlying cause gr	ven in Part I.	23e. Did 1	tobacco use contribute	to the cause of death?
or dis	en sig ould b							10	Yes 2 No 3 F	robably 4 Unknown
Vital Records, sicien: The law requires t	20	Completed						24a. Was	psy prior to	autopsy findings available completion of cause of
프 를	page,	S						1 ☐ Yes	ormed? death? 2 No 1 □ Ye	
Vita icien	certiticete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			her	eath (Check only		
	r this raidi	5.	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	III 3LI DOA	4 Li Nursing		idence 6 Other (Sp how injury occurred	ecify)
Division of or Attending Phys	th. : Atte	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day Y	ear) Injury		ork?]Yes 2∐No			
Vis	actor by th	III C	3 ☐ Suicide 6 ☐ Could not determine			reet, factory, office			Street and Number or F wn, State)	Rural Route Number,
	rs ette	Cer		Danielly, other						
Hospitai	within 24 hours etter death. To the Funeral Diractor: Atter this certificate ha compietely filled in by the tuneral director, page		(Check only 2 Medical Exa	Physician: To the best of raminer: On the basis of ex	amination and/or ir	th occurred at the to	ime, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
To the	thin 2 the mplet	Medical	29b. Signature and title of certifier	and manner states		29c. Licen	se number		29d. Date signed (Mor	nth, Day, Year)
ì	3 H 8		155 FISKIN	odlo	MO	Doc	06243	35	6/10/2	2006
0	(2)		30. Name and address of person who	o completed cause of deal	th (Item 23a) (Type	Print)	n o	0 1-	6/10/2 11e, MI)	2. CF-
_	رب		SHYED EIS	AYYAO	971 Neo	hila lent	er Ur.	Rockvi	He, MI)	10220
	St Regist	tate trar	31. Date filed (Month, Day, Year) JUN 1 5 20		Signature					

WHREN, Luella

	H 11-52		1 - For State Registrar	State of Marylar				lealth and Death		-	Reg. No.	1000	20	574
8,	Physici /Medic		1. Decedent's Name (First, Middle, Last) Lymon Aaron	Wooten						Date of Dea Month June	Day 8	2006	3. Time of 1:5	
	Examin Funeral Director	er 	4a. Facility Name (If not institution, give s Gladys Spellma: 5. Social Security Number 6. Sex 212-44-4947	n Nursing H		Ch If Unde	ever ever er 1 Year Days	If Under 24 F	in. 8	Date of Birt (Month, Da)	h y, Year)			or Foreign
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other then "natural", or itema 23a or 28a-f ehow eny injury or other traumetic event, the Madical Example must be notified at ODGs.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD. Prince 10e. Street and Number 4916 Colonel Ad	dison Place 12. Was Decedent Ever in U Armed Forces? 13. Was Decedent Ever in U Armed Forces? 14. Was Decedent Ever in U Armed Forces? 15. Was Decedent	16a. Deceding (Give life.) ASSi 19b. Mailin 4916 Place of Disponentery, cren nel ten	was December 10f. Z Was December 1 Yes dent's Usikind of w DO NOTO Stall CO. Sition (Namiatory or ham)	p Code D 7 7 2 dent of Federity Cubic 2 2 No ial Occupork done use retired nt F s (Street L one Vet ind Addre	sand Number or and Number of and Number of all Additional and Number or all Additional and Number of Additiona	(Specification (Speci	Mnger First, Middle, arris Route Number	10g. Citi Uni 16b. Ki Fe Maiden On on, City o , Up 20c. Lo Ch	zen of What Co ted St 14. Race - Arme Black, Whit Specify: B1 and of Business deral Sumame)	10d. Inside C 1 □ Yes Puntry? ates Ack Industry Gov't Zip Code) 2(r1bord Town, State am MD	D772 D MD
8760,	Physician /Medical Examiner prize pr	Ical Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Congestive Due to (or as a consect Ventricul Due to (or as a consect Ventricul Cerebral Va	re Hea quence of): Rena quence of): ar De quence of):	rt l	Fail isea dent	ure se Respr	rira			ilure	Approximat Interval Bet Onset and I	ween
P.O. Box 68	Physicien: The law requires that the death certificate be executed this certificate has been signed by the ettending physician and rail director, pege 2 should be detached for use as the burial-transit	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	ideath 3□	Ectopic p Other (s		y			2	23d. Date of del Month		√ear
Records, P.	iaw requires that t as been signed by 2 should be detai	Completed by Ph	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying	cause giv	ven in Part I.	_	23e. Did to	es 2[24b. Were au	obably 4 Dutopsy findings	Jnknown available
of Vital Re	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has cumplately filled in by the funeral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2		ER/Outpatier			4 140(3)(1	g Home	perför 1 ☐ Yes Check only o	rmed? 2∭No <i>ne)</i> dence (death? 1 Yes	2□ No	4438 VI
Division of Vital	of or Attending after death. I Director: After d in by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h building, etc. (Specia	Injury ome, farm, str	М		yat k? Yes 2 □ No	281	_	Street an	d Number or Ru	ral Route Num	ber,
	To the Mospitel or within 24 hours after To the Funeral Dir cumpletely filled in	Medical C	29a. Certifier (Check only one) Certifying Phys	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death ation and/or in	vestigatio	n, in my c	pinion, death o	age and ccurred	dual, the a	rausa(s) date and	and manner as place, and due	unled to the cause(s)
	1 1 1 E	Σ	29b. Signature and title of certifier 30. Name and address of person who od	mpleted cause of death (Iter	n 23a) (Trees	1) Z_{J}	757	7			e signed (Mont	, ,	
12	Sta Registi		31. Date tiled (Month, Day, Year) 31. Date tiled (Month, Day, Year) 2006	32. Registrar's Signa	3001	Hos	pit	al Dri	Vio.	Ches	rer1	y MDL	, 20785	

			For State Registrar	State of Ma	•	epartmen Certificat			Mental I	Hygier Reg.	11	06	20	575
			1. Decedent's Name (First, Middle, Last,						2. Date of Month		Day	Year	3. Time o	of Death
	Physici /Medic		James Hamilton	Windsor					June		2006	1041	2:55	Ам
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,		Location of Deat	h		4c. County		•	
			Southern Maryland					inton			Pri		George	
	Funeral		5. Social Security Number 6. Sec. 127-36-8453	x XM 2□F	e (In yrs. last birth 83 Y	8.4 - m 4 lm m	Days	If Under 24 Hrs Hours Min.	8. Date of (Month	. Dav. Ye	1922	9. Birthp	lace (State	or Foreign
	Director		Usual Residence of Decedent						Dec.	29,	1922	Mary	Tanu	
	/land		10a. State 10b. County		10c. City, Town	or Location						1	0d. Inside (City Limits
	Man	tor	Maryland Prince G	eorge's	Upper	Marlbo	ro						1 🗌 Ye	s 2X No
	or 28	lre	10e. Street and Number			10f. Zip	Code			10g.	Citizen of	What Cour	ntry?	
	23a (Funeral Directo	13116 Molly Berry	Road				20772	2		US	SA		
	r dea	nue	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Dece If Yes, spe	dent of Hi	spanic Origin? (S n, Mexican, Puer	Specify Yes o to Rican, etc.	r No-)		e - Americ ck, White,	an Indian, etc.	
9	s efte , or It	by Fi	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X ☐ I If Yes, Give Year or Dates:	No	1 ☐ Yes	∂ C No	Specify:			Specif	y:	White	
Maryland 21215-0036	hour tural	d be	15. Decedent's Edu		16a	Decedent's Usu	al Occupa	tion		166	. Kind of B	usinges/In	dustry	
ņ	in 72	Completed	(Specify only highest grad	e completed)			rk done d	uring most of wa	rking	100	, Killa of S	031110337111	dustry	
2	the in the interest of the int	E o	Elementary/Secondary (0-12)	College (1-4or	5+)	Farmer					Agr	ricul	ture	
ַ	be filed within 72 hours efter death with the Maryland tiel Hygiene. dother then "naturel", or Items 23e or 28e-f ehow event, I're Medical Examinar must be notified at	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Mic	ddle, Maid	den Suman	10)		
<u>a</u>	Aente Aente rked	ToE	Wade Windsor					Mai	ry Alio	ce Ki	idwel			
a	and Name	13	19a. Informant's Name/Relationship (7)					nd Number or R						770
Σ	end 2 salth n 27 l		Ruth P. Windsor	- Wife				erry Roa		-				112
ore	of He		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	Removal from State	cemetery	Disposition (Na v, crematory or o	ther place	9)	Date		. Location		_	
Ĕ	Pag ment ant: l		4 □ Donation 5 □ Other (Specify)		St. Ir	nomas Ce	emete	ry 6-2			room,			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mentel Hygiene. Department of Health and Mentel Hygiene Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 show any high or other traumatic event, its Medical Examinar must be notified at 200c.		21. Signature of Funeral Service Ligens	98	M01391	22. Name a		al Home					n Roa MD 20	d 604-01
8760,	Physician /Medical Examiner but sician ond physician ond physician ond sician site private in the private in th	dicai Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sup to (or as b. Due to (or as c. Q NZ	a consequence of a cons	(1): Ob	51) H	retra					100	de la
P.O. Box 68	law requires thet the death centificate be executed es been signed by the attending physician end 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ⊟Ectopic p 5 □ Other (s)				_		te of delive	ery Day	Year
	w requires thet to be a signed by should be detact	by	Part II. Other significant conditions co	intributing to death t	out not resulting in	the underlying	ause give	n in Part I.		Did tobac		tribute to th	he cause of	death?
5	need	etec	174000120	0 A	Λ					-				
Vital Records,	hes to ge 2 s	Completed	Caro way	mesy	XSPA	F			1 8	Mas an autopsy performed	i	Were auto prior to co death?	psy finding mpletion of	s available cause of
a	ician: The certificate hi rector, page								1 □ Y	es 2		1 🗌 Yes	2□ No	
₹	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 🗸		-57.0	Othe	26. Place of De						
ō	ding Phys		27. Mariner of Deat	28a. ate of Inju (Month, Da	ury 28b. T		28c. Injun Work	4 🗀 Nulsing	28d. Desci				y)	
Division	or Attending aftar death. Director: After in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	286. Place of In	jury - At home, far tc. (Specify)	rm, street, factor		_		on (Stree r Town, S		oer or Rura	al Route Nu	mber,
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	edical Ce	29a. Certifier (Check only one) 29a. Certifying Physics Certifying Ph	rsician: To the best iner: On the basis of and manner si	of examination and	, death cecumsod/or investigation	at the tim	e, date and place pinion, death occ	e, and due to urred at the ti	the caus ime, date	e(s) and m and place,	anner as s and due to	lated. o the cause	(s)
)	To the within: To the comple	Med	29b. Signature and title of certifier	Zzer	dondors	29	c. License			29d.	Date signe	d (Month,	Day, Year)	
			20 Name and address of access with	ompleted sauce of	death (from 22-)	Tuna Brist'	UW	1923			2/1	,		
<	165		30. Name and address of person who o	COD L / N	иевин (ленн 238) (И	WAS d	216	2 MD	4 17:	9				
	Ct	ate	31. Date filed (Month, Day, Year)	32. Refist	rar's Signature	W '7) O	4000	1313	det	01				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland Department of Health and Mental Hygiene

			State of Marylan		te of Death		g. Nq. (6 20576
		1. Decedent's Name (First, Middle, Last)				2. Dete of Deet Month		3. Time of Death
	Physician /Medical	JESSIE R	WALKER			JUNE 12		04:00
	Examiner	4e Fecility Neme (If not institution, give :	•			r Location of Deeth	4c. County o	f Deeth
		CALVERT MANOR N			RISING		CECIL	
	Funeral Director	130-20-2373	7. Age (In yrs. 78	last birthday) If Und Yrs. Months	er 1 Year If Under 24 Hi s Days Hours Mi		Yeer) 1928	9. Birthplece (State or Foreign Country) SOMERVILLE, NJ
	pue *	Usuel Residence of Decedent 10a. Stete 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	Maryle 1 sho	DE NEW CAS		W CASTLE				1 ☐ Yes 2X No
	15 28 TO	10e. Street end Number		10f. Z	ip Code	10	g. Citizen of W	hat Country?
	A with	6 BOSTON PL			19720		USA	
Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of health and Martel Hyglene. Important: If them 27 is marked other than "naturel", or items 23a or 28a-f show stary fujury or other traumatic event, the Medical Examinar must be notified at ance. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		edent of Hispanic Origin? ecify Cuban, Mexicen, Put 2 X No Specify:	(Specify Yes or No- erto Rican, etc.)		- American Indian, , White, etc. WHITE
9	2 hot	15. Decedent's Edu	cetion	16e. Decedent's Us	ual Occupation	rodina	16b. Kind of Bus	iness/Industry
215	o o o	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		vork done during most of w use retired)	Orking		
21	od wil	12		SALES				CLOTHING SALES
pu	d oth	17. Father's Name (First, Middle, Last)	3.0			ame (First, Middle, M)
χ	Mentel Mentel Merked of	FRED MOS			ANNA		AKATURA	No. 1. 70- 4-1
Mai	12 sh h end rem	19a. Informent's Name/Reletionship (Ty			ss (Street and Number or a			state, 2ip Cooej
	Healt Healt Fm 2	JANET ARCHER/ DAUG 20a. Method of Disposition	20b. F	Place of Disposition (N	ame of	EWARK, DE		City or Town, State
Baltimore,	Peges nent of int: If its iny or o	1 ☑ Burial 2 ☐ Cremetion 3 ☑ R 4 ☐ Donation 5 ☐ Other (Specify)	emovel from State	cemetery, cremetory or CFT.AWN MFM	rother place) IORIAL PARK		NEW CAS'	
Ħ	artme professional Injury	21. Signature of Funeral Service Licensi						UNERAL HOMES INC
Ba	permit. Departimonta any inje	V lah	wh.		N DUPONT PKW			
		23d. Pert1. Enter the diseese, or complishock, or heart failure. List only or	cations thet caused the deat					Approximate Interval Between
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	TROUSUEN	SE MYOUT	15.			Onset and Death
-	nsit)		n.			1
Č,	icate be executed physician and sthe burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	Due to (d	or es e consequence d	n):			
68760,	flicete be g physician as the buri	Ceuse (Diseese or injury thet initieted events resulting in death) Lest	Due to (o	r as e consequence of	j):			
89								1
Вох	tendi or use							
0	the el hed for	Part II. Other significant conditions con	tributing to death but not res	ulting in the underfying	cause given in Part I.	23b. Did to	bacco use cont	tribute to the cause of death?
P.0	v requires that the deeth cer been signed by the ettendin should be deteched for use letted by Physician/N	ATRIAL FIBRILL	GATO			1 □ Y	2 No	3 Probably 4 Unknown
ds,	signed by	POLICYTHEMA VE		-		24a. Was e	n autopsy	24b. Were autopsy findings
Records,		TOLTCYTHIMA VE	NA			perform	ned?	available prior to completion of cause of death?
Re	yystelen: The lew his certificate has be I director, page 2 s To Be Comple					1DIY	on We a	1 ☐ Yes 2 ☐ No
	stan: T	25. Was case referred to medical	-		26. Place of D	eath (Check only on	7	
of Vital	Physician: this certific ral director,	examiner?	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 1		Home 5 ☐ Reside		r (Specify)
	g Physerthis seral di	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho		
jo	Attending or death. Sctor: After by the fune fune fune fune fune fune fune fun	1 Accident 5 Pending investigation	(, 25)	M	1 ☐ Yes 2 ☐ No			
Division	or Attendenter de Mrecto in by the striffic	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, street, factory)	ory, office	28f. Location (St City or Town		r or Rural Route Number,
	To the Hospital or Attending Phy within 24 hours effer death. To the Funeral Director: Affer thi completely filled in by the funeral Medical Certification: 1		sician: To the best of my kno ner: On the basis of examina					
	ithin 2 the omple	29b. Signature and title of certifier	end manner stated.	2	9c. License number	2	9d. Date signed	(Month, Day, Year)
	₩¥ \$ \$ \$ \$ \$	D. V.			458419		UNE 13, 2	
•		30. Name end eddress of person who co	mpleted cause of death (Iter	n 23e) (Tyne Print)	1100711		- 7, 5	<u> </u>
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	.5	KODINGS DOWNAM I	10' 1931 LESES	WAR ROOD	RISIM SUN MY)		

			For State Registrar	State of Maryland		ertment of He tificate of D			giene Reg. No.	06	2057	7
ı	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day	Year	3. Time of Death	
	/Medic			n Willoughby				June		006	2:30 P M	4
	Examin	er	4a. Facility Name (If not institution, give str	,		4b. City, Town, or	Location of Death		4c. County			
			Ruxton Health of Der 5. Social Security Number 6. Sex	7. Age (In yrs. la	ast hirthday)	Denton If Under 1 Year	If Under 24 Hrs.	9 Date of Birth		line	place (State or Foreig	
н	Funeral Director			4 2 DF 96	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day		Cou	intry)	1.8
			Usual Residence of Decedent	7.0				September	1, 1909	LUEX	aware	
	nylan ihow	L	10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits	
	Ba-f s	cto	Maryland Caroli	re Fe	ederal.						1 ☐ Yes 2 ☐ No)
	vith th		10e. Street and Number			10f. Zip Code			10g. Citizen of		,	
	s 23e	rai	614 Old Denton Road	. Was Decedent Ever in U.S	10.1	21632	i- Q-i-i-0 (Q-				s of Ameri	c
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show aumatic event, It e Madical Examinal must be natified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	l II	Vas Decedent of His Yes, specify Cubar ☐ Yes 2☐ No	Specify:	Rican, etc.)		ck, White,	ican Indian, , etc. UCASLAN	
Ö	72 ho	ted	15. Decedent's Educa (Specify only highest grade of	tion	16a. Deced	ent's Usual Occupa	tion	200	16b. Kind of B			
2	Ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done do OO NOT use retired)	aring most of work	ng				
2	filed wi Hygien other th	Co	8		H	omemaker				ome		_
Maryland	outd be fil Mental H arked ott atic even	Be	17. Father's Name (First, Middle, Last) William Hitch	4			18. Mother's Name			10)		
څ	shoutd nd Men marke imaric	J.	19a. Informant's Name/Relationship (Type		10h Mailin	g Address (Street a	Anna ad Mumbar ar Purr	(unknow		Ctata 7	- Codel	
<u>N</u>	d 2 s th an t7 is i		Elbert Willoughby	Son		ickney Dr					b Code)	
ନ୍	is 1 and 2 should of Health and Men item 27 is marke other traumatic		20a. Method of Disposition			sition (Name of natory or other place		Decui	20c. Location		own, State	-
altimore,	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify) 21 ☐ Imparture of Funeral Service Licenses		ipitol	Crematory or other place Crematory Name and Address	y 6/16/	2006 v	over, I	elaw)	are	
Ba	permit. Departr importe any inji		23a. Part l. Enter the disease, or complica	hour	Mo 12	ore Funer South Se	eal Home, econd Str	P.A. Der	nton, M	arylı	and 21629	
П		ž	shock, or neart failure. List only one	tions that caused the death cause on each line.			111 No.	or respiratory arr	est,		Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	alpheni	us	Dem en	fea				logis	
	Examiner			Due to (or as a consequ	ence of):						U	
		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):					-		\dashv
	uted d ansit	Examin	Cause (Disease or injury that initiated events									
o,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):							
58760,	ate be nysicii he bu	edicai	d									
_	artificz ing pt e as t		IF FEMALE:									
Вох	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/M	23b. Was decedent pregnant 23c	If yes, outcome of pregnar 1□Live birth 2□Fetel	death 3	Ectopic pregnancy				te of delive	ery Day Year	
o.	at the de by the a tached	ysic	in the past 12 months? 1 ☐ Yes 2 █️No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown	atn 5⊔	Other (specify)						
۹.	res that tigned by		Part II. Other significant conditions contri	buting to death but not resu	Iting in the un	derlying cause giver	n in Part I.	23e. Did to	bacco use cont	ribute to t	he cause of death?	
ds	puires n sign	d by	Chronie bro.	nchiectan	Ŝ			1 □ Y	es 2 No	3 🗆 Prot	pably 4 Unknown	
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	The la	шо						autops	med?	prior to co death?	mpletion of cause of	i
ita		0	25. Was case referred to medical			·	26. Place of Death			1 🗌 Yes	2□ No	-
>	ysici is ce direc	To B	examiner? 1 Yes 2 No	spital: 1 Inpatient 2 E	ER/Outpatient	Other	17.			er (Specit	5v)	٦
Division of	ding Ph h. After th funeral		27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho				
0	endir sath. or: Al	atlc	2 Accident investigation				es 2 🗆 No					
Ž	tei or Attendii s after death. el Director: A ed in by the fu	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	 Place of Injury - At hor building, etc. (Specify) 	me, farm, stre	et, factory, office	1	28f. Location (St City or Town		er or Rura	al Route Number,	
	urs al	O										_
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,	edical	29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☐ Medical Examine	ian: To the best of my known: On the basis of examination and manner stated.	on and/or inv	estigation, in my opi	nion, death occurr	and due to the ca	ause(s) and ma ate and place,	nner as s and due to	tated. o the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	Me uno		29c. License	number	. 2	9d. Date signer	1 (Month,	Day, Year)	
			1 Selection	ecc.		V S	>1 007		6/15/	06		
			30. N and address of Arson who com		23a) (Type, F	S. (Jech)	retur.	St Po	ston .	MA	21601	
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure C	,. 00-0-00	8	. —		.,	7001	-
	Registr		JUN 1 6 200		N 19	29c. License D3 Print) CJashi						

			For State Registrar	State of M	aryland / De	partmen e <i>rtificat</i>			and M	ental Hy	giene Reg. No	cuub.		178
	Dhysiai	20	1. Decedent's Name (First, Middle, Last							2. Date of De Month	eath Da	y Year	3. Time of	Death
	Physicia /Medic		Janet Emily We							June	19	2006	5:50	Α ^M
	Examin	er	4a. Facility Name (If not institution, give	street and number)				Location of			4c.	. County of Death		
			22821 Lewis Lane					on Pa				t. Mary'		
	Funeral		5. Social Security Number 6. Se	X JM 2XIF / Ag	e (In yrs. last birthda 7 E Yrs.	y) If Under Months	Days	If Under Hours	Min.	8. Date of Bi	ay, Year)	Cou	place (State or intry)	Foreign
	Director		577-40-3944 Usual Residence of Decedent		75 Yrs.					Ju1y 8	, 19	30 New	Jersey	
	land		10a. State 10b. County		10c. City, Town or	Location							10d. Inside Cit	y Limits
	Man Frah	ţō	Maryland St. M	fary's	Т.	exingt	on F	Park					1 🗌 Yes	2 ∑ No
	r 288	Director	10e. Street and Number			10f. Zip		alk			10g. Cit	tizen of What Cou	intry?	
	73a o	a D	22821 Lewis Lane				206	553				United S	States	
	deat	Funeral	11. Marital Slatus	12. Was Decedent Armed Forces?	Ever in U.S. 1	3. Was Deced			gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Amer	can Indian,	
9	or ite		1 Never Married 2 Married	1 ☐ Yes 2X	No	1 Yes		Specify:		nicari, etc./		Black, White Specify: Wh	ite	
21215-0036	n 72 hours after death with the Maryland "natural", or itema 23a or 28a-f ahow edical Exarchar mast be notified at	d by	3X Widowed 4 □ Divorced	Year or Dates:				opcony.				Specify. WI	iile	
<u>2</u>	72 h	Completed	15. Decedent's Edu (Specify only highest grad		(Gi	ve kind of wo	rk done d	during most	t of workir	ng	16b. K	ind of Business/li	dustry	
12	d within piene. r than the Mex	d L	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT u			NT	_		1.1		
22			17. Father's Name (First, Middle, Last)		LICE	nsed P	ract			(First, Middle		ealthcar	e	
and	ed la de	Be									, mardor.	oumame)		
2	d 2 should the and Ment	ဥ	George Lange 19a. Informant's Name/Relationship (Ti	voe. Print)	19b Ma	uling Address	(Street :			cobis	ner City o	or Town, State, Zi	n Code)	
Maryland	T te		Christine Davis /											E 2
ē,	s 1 and 2 f Health itsm 27 other tr		20a. Method of Disposition	Daugneer	20b. Place of Dis	position (Nar	ne of			ate		Mary 1a		33
2	00		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Brinsf/e	rematory or o		1	20	2006	Ch	1	11 100	
Baltimore,			21. Signature of Funeral Service Lice	100							Char	lotte Ha eral Hom	111, MD	
Ba	permit. Departr import any in		Edward N. Brinsfie	Id. Ir.	M00052 2									
			23a. Part1. Enter the disease, or comp	lications that cause	d the death. Do not							own, MD	Approximate),
	Obvesialan		shock, or heart failure. List only o	one cause on each	ine.	1		Fail	1.0	1			Onset and D	
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of:	wy	4	cerc	we	<u></u>			day	$\tilde{x}r$
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	be executed siclan and burial-transit	Examin	Cause (Disease or injury that initiated events		nd Stat	FC 318	(500	al	D,	کر ۔			US	11
o	an ar an ar irial-t		resulting in death) Last	Due to (or as	a consequence of):	X	1						1	
8760	death certificate be executed e ettending physician and ad for use as the burial-transit	Physician/Medical	•	d		V								
99	ing pl	Med	IF FEMALE:											
Box	eath certific ettending pl	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pr						23d. Date of deliver Month	,	ear
Ö	the e	/slci	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of death	5 Other (sp	ecify)					WORK	Day 1	oai
P.0	The law requires that the de ite has been signed by the c page 2 should be detached		Part II. Other significant conditions co	ontributing to death h	out not reculting in the	. undochina a		an in Bort I		23a Did	tobacco	use contribute lo	the serves of d	nath?
ds,	signe signe d be d	ρ	Tarri, outer eight contained to	minouting to death t	out not resulting at the	s underlying c	ause givi	en in raiti.	•			ØNo 3□Pro		
Ö	w require been si should t	etec	1 2	110	7	1				-				
Records,	elaw hasi	Completed	- Co ronan	1 17/US	ry c	*				24a. Was		24b. Were aut prior to o death?	opsy findings a ompletion of ca	ivailable luse of
a			· ·		Y					1 ☐ Yes			2 (2) No	
Vital	9 9	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:			Oth			(Check only				
of	Phys r this oral di	-	27. Manner of Death	28a. Date of fnji (Month, Da	ent 2 ER/Outpa			4 110		ne 5 Res 8d. Describe		6 ☐Other (Spec	fy)	
Ö	ding th. Th. After funer	tior	1 ∰Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Injur	y M	8c. Injun Worl	k? Yes 2 □:	i			,		
Division	or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	286. Place of in	jury - At home, farm,	street, factor	, office		2	8f. Location	(Street ar	nd Number or Rui	al Route Numi	ber,
á	i i te	Certification:	4 Homicide determined	building, e	tc. (Specify)					City or To	wn, State	9)		
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Phy	ysicien: To the best	of my knowledge, de	eath occurred	at the tin	ne, date an	d place, a	nd due to the	cause(s) and manner as	stated.	
	he Hon 24 n 24 he Fu	edical	(Check only 2 Medical Exem	and manner st	of examination and/or ated.	investigation	, in my o	pinion, dea	ilh occurre	d at the time	, date an	d place, and due	to the cause(s)	
	To t To t	Σ	29b. Signature and title certifier	011	1	290	. License	e number	1111	G	29d. Da	te signed (Month	Day, Year)	
,	_		ams	14 Bul	TELVIII		D	DE	541	7	6.	-20-6	16	
2	v		30. Name and address of person who o	//						1				
	١	Į	James P. Jarboe,	M.D/, 240	35 Three	Notch	Road	, Ho1	1ywo	od, Ma	ryla	nd 20636		
	Sta Registi		31. Date filed (Month Day, Year)		rar's Signature	and I								

Raymond S. Ward, Sr.

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		For State Certifical	e o	f De	ath					eg. No.			
Physician edical Examine	1	. Decedent's Name (First, Middle, Last) Raymond S. Ward, Sr.						- 1	Date of Dea Month June 7, 2	Day 006	Year		3. Time of Death 1230 hrs
	4	la. Facility Name (if not institution, give street and number) 15772 Jackson Lane, Goldsboro, MD			ty, Town		cation of	Death			County of aroline	Death	
Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	lay)		Jnder 1		If Under	24Hrs.	8. Date of B		D/YYYY)	9. Birt	hplace (State or
Director		248-29-8952 1⋉м 2□F 41	Yrs		onths [Days	Hours	Min.	12-14-	-1964		Foreig Cou	n untry) S.C.
	ι	Jsual Residence of Decedent	_										10d Inside City Limits
w any		10a. State 10b. County 10c. City, Town or		tion									1 Yes 2 X No
daryland 28a-f show 1 at once.	힑-	Delaware Kent Magnol	ia	10f.	. Zip Coo	de				10g. Citiz	en of Wha	at Cour	ntry?
th the Mary 23a or 28a notified at	Director	129 W Terry			19	962				USA	Д		
with the ms 23a be not		11. Marital Status 12. Was Decedent Ever in U.S.							ofy Yes or No		_		can Indian, Black,
or iter	Funeral	1 Never Married 2 1 Yes 2 X No			2 X						Specify: 🏻		.le
hours after "natural",	⋧┞		ecede	nt's Us	sual Occ	upatio	n (Give ki				ind of Bus		
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e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Filem 27 is marked other than "natural", or items 23a or 28a-f she ir raumatic event, the Medical Examiner must be notified at once	Becc	17. Father's Name (First, Middle, Last) Woodrow Mc Fadden				10	Bess	sie l	irst, Middle, Richar	ds	wers		
212 buld be Menta mark ic even			Mailin	ng Add	iress (S				ral Route Nu	mber, Cit	ty or Town	, State	, Zip Code)
MD and 2 sho alth and 27 is raumati									ton,D	elawa	are 1	994	13
re, s l and of Heal If iten	- 11	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State cremato				of ceme	etery,		Date	20¢. L	ocation -	City or	Town, State
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Plygene, Important: If item 27 is marked other thingings or other traumatic event, the Medinjury or other traumatic event, the Medinium of		4 Donation 5 Other Specify: Wilson					of Faculity				11ywc	od,	S.C.
Balti permit Departn Import injury (21. Stenature of unever Service unise		inn 17	ie S	mit	h Fu	nera Str	1 Hom	e Dove:	r. De	elaw	are 19904
Physician	\dashv	23a, Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	enter	the m	ode of dy	ying, sı	uch as ca	rdiac or r	espiratory a	rest, sho	ck, or hea	rt	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Shotgun Wound of the Head											Death
Zadilliloi		or condition resulting in death) Due to (or as a consequence of):											
	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause											
	Εħ	Cinsease or injury that initiated events resulting in death) Last		-		-							
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O, e be ex sician	n/Medical	UNPENDED X AMENDED#18, F. D., TC	π,	06/	14/2	2006	o,sbi)		230	d. Date of	deliver	v
58760, crificate be executed ling physician and sas the burial - trans		23b. Was decedent pregnant in the past 12 months?	F	etal d	eath	3	Ectopic	pregnan	су	- 1	Month		Day Year
that the death certificate by the attending detached for use as	Physicia	4 Pregnant at time of death 5 Yes 2 No 9 Unknown 9		Other	(Specify))							9
O. B at the d I by the	F.	Part II. Other significant conditions contributing to death but not resulting	in the	unde	rlying ca	use giv	ven in Par	rt I.					the cause of death?
ires that signed I be de	d by										-		bably 4 Unknown
ords, w requir	Completed									s an opsy formed?	р		utopsy findings available completion of cause of
Rec The la cate ha	팃								1 🗸 Yes			VY	es 2 No
Vital Reorgician: The his certificate director, page	a	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Ou	ıtnatie	nt 3	26.1	10	of Death (Other		Home 5	Reside	ence 6	∕ Othe	er: Scene
n of Vi ling Phys After this funeral di	ے ا	1 Ves 2 No	,	f Injury			at Work	? [2	28d. Describ		ury occum	ed	
On Constant	ţi	1 Natural 5 Pending Jun 5, 2006 real) 2300	hrs		1	Y	es 2 🗸	No	Subject sh				
Divisi pital or Att ours after d teral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) Field	rm, str	eet, fa	actory, of	fice bu	iilding, et		28f. Location or Town Dover, D		and Numbe	er or R	ural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dear one) Medical Examiner: On the basis of examination and/or in	ith occ	urred pation,	at the tin	ne, dat oinion,	e and pla death oc	ce, and c	due to the ca the time, da	use(s) an te and pla	nd manner ace, and d	as sta	rted he cause(s)
To with To com	Mec	29b. Signature and title of dertifier			29c. L	icense	number						onth, Day, Year)
		SKI/ JANX IV \				D.C.N	1.E. 			Jun	e 8, 20	06	
-1/2 -		30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 1	11 Pe	enn S	Street	Balti	more, N	/ID 212	201				
9	ate		<i>A</i>	المان									
Regist		I I I I I I I I I I I I I I I I I I I)				-				
DHMH 17 Rev 1/2	001	ŐR	IGIN	AL									

DOROTHY P.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	;	State o	of Mary	land / De		ent of F ate of			-	giene Reg. No.	006	20580
			1. Decedent's Name (First, Middle	e, Last)								2. Date of De			3. Time of Death
	Physici /Medio		DOROTHY PEARL	WEBI	ΣR							JUNE	15 Day	2006	5:20AM M
	Examir		4a. Facility Name (If not institution	n, give str	eet and nu	mber)		4b. Ci	ty, Town, o	r Location	of Death	1	4c. Cou	nty of Death	
Н			WILLIAM HILL	GARD	ENS				EAS	STON				TALBO	\mathbf{T}
	Funeral		5. Social Security Number	6. Sex	V	7. Age (Ir	yrs. last birthda		er 1 Year		r 24 Hrs.	8. Date of Bir	th Year)	9. Birth	place (State or Foreign
L	Director		175-10-2476	1 🗆 1	и Ж ЭF	9	1 Yrs.	Month	s Days	Hours	Min.	JAN 9	1915	P	a (ry)
	p .		Usual Residence of Decedent												
	how	_	10a. State 10b. County			10	c. City, Town or	Location							10d. Inside City Limits
	Ba-f	Director	MD T	YTBO.	<u> </u>		1	ASTO	N						1 ¥Yes 2 No
	or 28	Sre	10e. Street and Number					10f.	Zip Code				10g. Citizen	of What Cou	ntry?
	death with the Maryland ms 23a or 28a-f ehow finutt be notified at		545 CYNWOOD D	RIVE				İ	2	1601				USA	
	dea	Funeral	11. Marital Status	12	. Was Dece	edent Ever	r in U.S. 1	. Was De	cedent of H	lispanic O	rigin? (Sp	ecify Yes or No Rican, etc.))- 14. F	Race - Ameri	
٥	or It	臣	1 Never Married 2 Mar		1 ∐Yes If Yes, Gir	2 (X No			2 X No			riloan, otc.)		THI	LTE
2-003p	hours after tural, or ite	d by	3 Widowed 4 □ Divorced		Year or D	ates:		1 🗀 1 63	244110	Specify	,.		Spe	cify: WH.	LIM
ດ່	72 h natu	etec	15. Deceder (Specify only highe				16a. De	edent's U	sual Occup work done	ation	st of work	ina	16b. Kind of	f Business/In	dustry
7	withln 72 ene. than "nai	de	Elementary/Secondary (0-12)	Ĭ	College (life	DO NOT	use retired	d) -		3			
7	filed w Hygier other th	Completed	8		0			DIET	ICLAN						CATION
yland	uid be filed within 72 hours after death with the Marylan lental hygiene. rked other than "natural", or Items 23a or 28a-1 show lice event, the Medical Examinar must be notified at its event, the Medical Examinar must be notified at	Be	17. Father's Name (First, Middle,	Last)						18. Moth	ner's Nam	e (First, Middle	, Maiden Surr	name)	
<u>8</u>		2	SYLVESTER E.	WERNI	≅R					F	LORA	BELLE N	IANN		
Mar	d 2 should th and Men 7 Is marks traumatic		19a. Informant's Name/Relations		_			_				al Route Numb			Code)
e) ≥	1 and Health em 27		ELISA WEBER MI	LLER	DAUGI					ALE 1	DR.,	EASTON,	, MD 21	.601	
ore	of Healt of Healt if Item 2		20a. Method of Disposition 1 Varial 2 Cremation	3	noval from	State	Ob. Place of Dis cemetery, c	oosition (A ematory o	lame of r other plac	эе)		Date	20c. Locatio	on - City or To	own, State
Ĕ	Pag ment ant: I		`4 □ Donation 5 □ Other (S	pecify)	noval nom	1	WOODLAWI	MEM	ORIAL	PARI	K 6/1	9/2006	EAST	ON, M	ARYLAND
aitimor	permit. Pages Depertment of I Important: If Ite any injury or of once.	1	21. Signature of Funeral Service	Licensee			\	22. Name	and Addre	s of Faci	lity	, C MITTER	1134 TUD	rm lr :	TONG D
מ	89 5 2		JOHN R.	m	ERC	ER:	, ~ !	200 S	ws, п . HAR	RISO	NDEID NDEID	EASTON,	MD 21	601	HUME PA
			23a. Part1. Enter the disease, or shock, or heart failure. List	complica	tions that c	aused the									Approximate Interval Between
	Physician		Immediate Cause (Final	,	2	1. 1.	1		0 0		44.	or PAI	1- K	/ -	Onset and Death
	/Medical		disease or condition resulting in death)	a	Due to	(or as a co	insequence of):	Wy		1, W	unt	9 -01	chy	1	wiln's Ho
	Examiner				MIN	AVIA	<in 1)<="" td=""><td>x Hel</td><td>MEL</td><td>and b</td><td>linil</td><td>rake?</td><td>Vascal</td><td>21</td><td>Herry</td></in>	x Hel	MEL	and b	linil	rake?	Vascal	21	Herry
		ē	Sequentially list conditions, if any, leading to immediate) v.	Que to	(or as a co	nsequence of):	~ nu	MOS Y	ur v	1/6/1	LAVIATO	I Com	1.10	1
	uted d ansit	声	cause. Enter Underlying Cause (Disease or injury that initiated events	8									dill	24.6	
,	icate be executed physician and s the burial-translt	Examin	resulting in death) Last	C.	Due to	(or as a co	nsequence of):								
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Q		edical		- u.		12	962						ing a Time		
ŏ	death certific e attending p id for use as i	Physician/M	IF FEMALE: 23b. Was decedent pregnant	230	. If yes, out								234 (Date of delive	20/
Ď	atte	clai	in the past 12 months?			oirth 2 🗆 nant at time		□Ectopic □ Other (pregnancy					Month	Day Year
j.	at the de by the a tached	ıysı	1 □ Yes 2 ☑ No 9 □ Unknown		9□ Unkno										
7	that led b deta		Part II. Other significant condition	ons contri	ibuting to de	eath but no	t resulting in the	underlying	cause giv	en in Part	I.	23e. Did to	obacco use co	etribute to the	ne cause of death?
coras,	law requires that as been signed b 2 should be deta	d by							_			10	Yes 2 No	3 □ Prob	ably 4 Unknown
Ö	peed	Completed													
ě	has has	Пр										24a. Was autop	osy	prior to coi	psy findings available mpletion of cause of
=	: The cate ha	S										1 Yes	rmed?	death? 1 □ Yes	2 🗆 No
IIai	Physician: The law this certificate has laid inector, page 2 s	Be	25. Was case referred to medica examiner?		-14-4-				_		e of Deat	h Check only o	ne		
5	Phyel r this c ral dire	ို	1 ☐ Yes 2 ☑ No				2 ER/Outpati	ent 3 🗆 t		4 N	ursing Ho	me 5□Resid	dence 6 🗆 C	Other (Specifi	y)
	ding P h. After t funera	on:	27. Manner of Death 1 ☐Natural 5 ☐ Pendir		28a. Date (/Mont	of Injury th, Day Ye	ar) 28b. Time Injury	of	28c. injun Worl	at k?		28d. Describe h	now injury occ	urred	
UIVISION	tendi death. tor: A the fu	catl	2 Accident investi	gation				М	1 🗆	Yes 2□	No				
Ë	irec irec	ertiflcation;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined	28e. Place buildi	of Injury - ing, etc. (S	At home, farm, : pecify)	treet, facto	ory, office			28f. Location (5 City or Tox	Street and Nur vn, State)	mber or Rura	l Route Number,
	spital or ours afte neral Dir filled in	0													
	e Hospital of 24 hours af e Funeral Dietely filled in	dical	Check only 2 Medical	g Physic Examine	r: On the ba	asis of exa	y knowledge, de mination and/or	th occurre	d at the tim	ne, date a	nd place,	and due to the	cause(s) and	manner as si	ated.
	0 0 0	0	one)		and mann	ner stated.			, •	,				-,	

State Registrar

31. Date filed (Month, Day, Year) JUN 1 6 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie



DHMH 17 Rev 1/2001

125750

29d. Date signed (Month, Day, Year)

			1 - State of Maryland / De	partment of Health and I Certificate of Death		ene 006 20581
	Physici	_	1. Decedent's Name (First, Middle, Last) Joseph Henry Young		2. Date of Death Month June 7	
	/Medic Examir	_	4a. Facility Name (If not institution, give street and number) 8600 Mike Shapiro Drive	4b. City, Town, or Location of Death	n	4c. County of Death Prince George's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min	8. Date of Birth (Month, Day, 1	
	Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o Maryland Prince George's Clinto			10d. Inside City Limits 1
	h with the 23a or 28	al Director	10e. Street and Number 8600 Mike Shapiro Drive	10f. Zip Code 20735	10	g. Citizen of What Country? United States
920	urs after deat	by Funeral	11. Marital Status 1 Never Married 2 Marned 1 Never Married 2 Marned 3 Xwidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any highry or other traumatic event, it a Model Examiner must be notified at ance.	Completed	(Specify only highest grade completed) (G	scedent's Usual Occupation live kind of work done during most of wor e. DO NOT use retired) Truck Driver	king	6b. Kind of Business/Industry Private
land 2	uld be fited Mental Hyg rked other	To Be C	17. Father's Name (First, Middle, Last) James Ernest Young		ne (First, Middle, Mi	
Mary	ind 2 shoralth and N			alling Address <i>(Street and Number or Ru</i> 01 Sweetbay Drive (
altimore,	Pages 1 a nent of He nt: If item rry or oths		20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition	sposition (Name of crematory or other place) Memorial Park 6/1		Oc. Location - City or Town, State Landover, MD
Balti	permit. Departm Imports any Inju		21. Signature of Funeral Service Licenson		Stewart F	uneral Home, Inc.
	Physician		23a Part. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Sudden Cardia		or respiratory arres	st. Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of): Sequentially list conditions b. Acute Myocard	ial Infarction		
	end end -transit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Coronary Arte Due to (or as a consequence of):			
8760,	icate be executed physician and the burial-transit	dicai	d. Atheroscleros	is		
.O. Box 6	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	quires that n signed t uld be dett	ρ Σ	Part II. Other significent conditions contributing to death but not resulting in th Hypertension	e underlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O.	The law require ate has been si page 2 should t	Completed	Hypercholesterimia		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
Z Ta	Physician: The this certificate har all director, page	Be	25. Was case referred to medical examiner? 1 Yes 2 X No	0.1	th (Check only one)	ce 6 □Other (Specify)
ion of	Attending Physic death. sctor: After this by the funeral di	ation: To	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) Injury	e of 28c. Injury at	28d. Describe how	
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town,	,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in I	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	, and due to the cau rred at the time, dat	ise(s) and manner as stated. e and place, and due to the cause(s)
0 0	To the within 2 To the complet	Σ	29b Signature and title of certifler DOWSON W	29c. License number DC12309	290	d. Date signed (Month, Day, Year) June 12, 2006
	(\mathcal{I})		30. Name and address of person who completed cause of death (Item 23a) (Ty Joseph Robinson, M.D. 106 Irving	St., NW #3600N, V	Washington	n, DC 20010
御湯湯	Sta Registi	. AL	31. Date filed (Month, Day, Year) JUN 1 6 2006	who	*	

			1 - For State Registrar	State of	Marylar	-	artmen				lental Hy	6	2006	20	582
		_	Registrar 1. Decedent's Name (First, Middle,	/ act)		Ce	rillicate	e or L	Jeam		2. Date of De	Reg. No.		3. Time o	f Death
П	Physici	an	Rosaria Ann								June	28 Day	2006	3:00	
1	/Medic Examin		4a. Facility Name (If not institution,		ber)		4b. City.	Town, or	Location of	of Death	ourie		County of Deat		a [™]
	Examin	er	Baltimore/Washin			enter	Gler						Anne Ar		
	Funeral		5. Social Security Number 6		. Age (In yrs.		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			hplace (State	or Foreign
P	Director		151-07-9281	1 M 241 F	85	Yrs.	MONTHS	Days	riodis	IVIIII.	Dec 4,	1920	New	Jersey	7
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside C	City Limits
	daryt	ō	Maryland Montg	omerv		lver Sp									2 ∑ No
	the the 286-	rect					10f. Zip	Code				10g. Citiz	en of What Co	ountry?	
	3a or	D	321 University	31vd. #13	3		20	901				Unit	ted Sta	ites	
	deat	ner	11. Marital Status	12. Was Dece	dent Ever in U	I.S. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	- 1	4. Race - Ame Black, White		
9	or Its	/Fu	1 ☐ Never Married 2X Marrie		2 🕅 No		1 ☐ Yes		Specify:		riloari, oto.,		Specify: Wh		
8	within 72 hours after death with the Maryland ane. then "netural", or iteme 23e or 28e-f show he Maricel Exemiter mat ke notified at	Completed by Funeral Director	3 Widowed 4 Divorced	Year or Da	tes:	10. 0	44- 11-	10							
15	n 72	lete	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usua kind of woi DO NOT us	nk done d se retired	ation <i>furing</i> mosi ')	t of work	ing	160. Kin	d of Business/	industry	
12	iene.	mo	Elementary/Secondary (0-12)	College (1-	4or 5+)		erical					Stat	te Gove	rnment	
ק	il Hygid other	BeC	17. Father's Name (First, Middle, L.	ist)							(First, Middle	Maiden S			
/lar	uld be Mental Irked c	To E	Thomas Romano						Ang	elin	a Yocco	dine			
Maryland 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan seriment of Health and Mental Hygiene. ortant: if item 27 is marked other then "netural", or iteme 23e or 28e-f show injury or other traumatic event, the Marical Examinar mant to a netified at a.	, y	19a. Informant's Name/Relationshi			1					al Route Numb			_	
	and lealth m 27		Frank M. Annunzi	ato / Hus					y Blv		. #133,				D
00.0	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		itate	Place of Dispo cemetery, crea	matory or o	ther place					ation - City or		
Baltimore,	t. Pa rtmer rtant: njury		Donation 5 Other (Sp.		Но	ly Cro	ss Cer	nete:	ry_ 7	/1/2	006	Broo	klyn Pa	ark, Ma	ryland
Ba	Depa Impo eny i		21. Eignature of Funeral Service 0	0		2.	/1107 T	a Addres	opa 7	y Hub	bard Fu	mera	l Home,	Inc.	1 220
	_		23a. Part1. Enter the disease, or o	omplications that ca	used the dea						e, Balt		e, Mary	Approxima	ite
	Dhysisian		shock, or heart failure. List o Immediate Cause (Final	nly one cause on ea	ich line	MAA.	10-	-1	17	-/	. Aha			Onset and	Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consec	puence of):	o cai	Elic	4 1	uf	ure po			1 1700	77
П	Examiner			. De	ment	Sa								340	ars
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Error Underlying	Due to (d	or as a consec	quence of):									
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с.											
760,	ate be executed hysician and the burial-transit	cal E	rooming in doubly east	Due to (c	or as a consec	(uence or):									
687	physicate physicate			d											
Box (death certificat e attending phy id for use es th	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo								2	3d. Date of del	ivery	
	that the death led by the atter detached for i	cla	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregna	nth 2⊟Feta antattime of o		□Ectopic pr □ Other (sp						Month		Year
P.O.	t the by the	hys	9 Unknown	9□ Unkno	wn										
	law requires that the as been signed by th 2 should be detache	by Physician/Med	Part II. Other significant condition	s contributing to de	ath but not res	sulting in the u	nderlying c	ause give	en in Part I.		23e. Did t	obacco us	e contribute to	the cause of	death?
ord	w requires to been signer should be contacted to the cont										10	res 2	No 3□Pr	obably 4 🗆	Unknown
Records,	lawr las be	Completed									24a. Was	DSV	24b. Were au	topsy findings	available cause of
<u>~</u>	: The law cete has t , page 2 s	Con										rmed?	death? 1 ☐ Yes	2 100	
Vital	Physicien: The this certificete ral director, pag	Be	25. Was case referred to medicat examiner?	Hospital:				Othe			Check only				
ō		2	1 Yes 2 No	1 1		28b. Time o		8c. Injury	4 🗆 Nu		me 5 Resident			city)	
O	Attending r death. ector: After by the fune	tion	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investiga		f Injury n, Day Year)	Injury	М	Work	<br Yes 2□	-		,,			
Division	Attender death	Hice	3 Suicide 6 Could no 4 Homicide determin	28e. Place	of Injury - At h	ome, farm, st	reet, factory	r, office			28f. Location (Street and	Number or Ru	ıral Route Nur	n <i>ber</i> ,
Ö	s afte	Certification:	4 Tiornicide	buildin	g, etc. (Speci	<i>'y)</i>					City or To	wn, State)			
	To the Hospitat or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the xaminer: On the ba	best of my kno	owledge, deat	h occurred	at the tim	ne, date an	nd place,	and due to the	cause(s) a	and manner as	stated.	e)
	the hin 24 the R	Med	one,	and mann	er stated.	4			number						3,
	To You'ld		29b. Signature and title of certifier	+ An	1 ret		1		-00°	911		Lou. Date	igned (M - ti	, Day, rear)	
	1		30. Name and address of person w	ho completed casts	of death	m 23a) /Tun-	Print)	W L	00	/ /	0	1	1	٧	
	V		Ellioff A	Tor bake	UN	1411	Made	Sa	Par	KI	Drive,	Color	Burn	19. Md	7106
1	Sta	ite	31. Date filed (Month, Day, Year)		gistrar Sign	ature	A-	500	-	-	1	0		Y - 4	1
ā	Registi	ar	JUN 3 0	2006	Muses.	B 1	cook	•							

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Dhynio		Registrar	ficate of	Death			Reg No.	Sime Will VI	0 4000
Physic	ian/	Decedent's Name (First, Middle, Last)				Date of De Month	ath Day	Year	3. Time of Death
edical Exam	iiner	Samyiah Renae Allen				June 27,		I Cal	0445 hrs
		4a. Facility Name (if not institution, give street and number)	4	4b. City, Town, o	r Location of Death	1	4c Co	ounty of Deat	h
		St. Agnes Hospital	ŀ	Baltimore				n/a	
Funera		5. Social Security Number UNK 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Yea	ar If Under 24Hrs	8. Date of E	irth (MM/DD/	YYYY) 9. Bi	rthplace (State or
Director		404	Van	Months Day		10/00	10005	Forei	auntra) . –
		1 M 2 F	Yrs.	6 23		12/02	/2005		MD
>		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Locati	lon.					10d. Inside City Limits
wan		Too. State	WIT OF LOCAL	1011					1 Yes 2 X No
and sho	١	MD Baltimore Ha	lethor	rpe					res 2 K No
aryla 8a-f	1 5	10e. Street and Number		10f. Zip Code			10g. Citizen	of What Cou	intry?
ne M or 2 ffed	Director	4767 Drayton Green		2122	:7		Unite	ed Sta	tes
death with the Maryland or items 23a or 28a-f show any must be notified at once.	<u>a</u>	11. Marital Status 12. Was Decedent Ever in U.S.	13. Wa		ispanic Drigin? (S	pecify Yes or N			rican Indian, Black,
ath v (em)	Funeral	1 X Never Married 2 Married Armed Forces?			n, Mexican, Puerto			White, etc.	
er de	F.	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1	Yes 2 X No	n specify		Soci	ecify: Whi	te
s aft rral"	<u>چ</u>	or Dates:			ation (Give kind of	work done		of Business	
21215-0036 uld be filled within 72 hours after death with the Maryland Mental Hygiene marked other than "natural", or items 23a or 28a-f she	Completed	(-, , , , , , , , , , , , , , , , , , ,			e. DD NOT use ret		100.14110	or Business	industry .
6 n 72 an " real !	l ë			,				,	
vithii ene er th	ਵੱ	n/a n/a	r	ı/a				n/a	
Hygi	၂ ပ	17. Father's Name (First, Middle, Last)			18.Mother's Name	e (First, Middle	Maiden Sur	name)	
21 be fi ntal rked	B	Emerson Allen			Rhonda	Means			
AD 21 2 should h and Me 27 is ma	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	g Address (Stre	et and Number or I	Rural Route N	ımber, City o	or Town, State	e, Zip Code)
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene th 27 is marked other than marke event, the Metican		Rhonda Mae Means (Mother)	4767	Drayton	Green, I	Haletho	rpe, N	1D 212	27
ore, MC s l and 2 s of Health a If item 27	-			sition (Name of ce	emetery,	Date	20c Loc	ation - City oi	r Town, State
imore, MD 2 Pages I and 2 shou nent of Health and N ant: If item 27 is no	1.7	Mentoval Itolii State	ematory or oth						
Lime Pag ment tant:				rematory		<u>/05/200</u>			
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: I fitem 27 is an injury or other transmatter.		21. Sig + ture of Funeral Service Licensee		Name and Addres	Hu	obard F	unera]	L Home	Inc.
		1 Come							ryland 21229
Physician		23a. Part I. Enter the disease, or complications that caused the death. D failure. List only one cause on each line.	o not enter th	he mode of dying	g, such as cardiac o	or respiratory a	rrest, shock,	or heart	Approximate Interval Between Driset and
/Medica		Immediate Cause (Final disease a. Sudden unexplaine	d death	in infan	cv (SUDI)				Death
Examine	1	or condition resulting in death) Due to (or as a consequence of):							
		Sequentially list conditions, b.							
	ē	if any, leading to immediate Due to (or as a consequence of):							
	Ē	cause. Enter Underlying Cause (Disease or injury that initiated							
, ,	Examiner	events resulting in death) Last Due to (or as a consequence of):							
ecuted and transit		d							
e ex	<u>ខ</u>	X unpended X amended item#5.pe	arFH 23	Ra 27 28a-	f.perME.g8	sa a/22/0	6 TT		
8760, tiffcate be executed ng physician and as the burial - transi	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregna		21,27,200	<u> </u>)) •) [22]		ate of deliver	Ŋ
	<u> </u>	23b. Was decedent pregnant in the past 12 months?	2 Fe	etal death 3	Ectopic pregna	ancy	Mo	onth	Day Year
Sox 6 leath cert e attending	5		h 5 Ot	ther (Specify)					
Box e death of the atter	S	1 Yes 2 No 9 Unknown 9 Unknown							
ort the	1 =	Part II. Other significant conditions contributing to death but not rest	ulting in the i						
			alling in the c	underlying cause	given in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
P.O. s that the gened by	<u>۾</u>		aning in the c	underlying cause	given in Part I.				the cause of death?
ds, P. quires that en signed	<u>۾</u>		aning in the c	underlying cause	given in Part I.	1Y	es 2 N	o 3 Pro	bably 4 🗸 Unknown
ords, P.C. Iw requires that as been signed is	<u>۾</u>		diang in the c	underlying cause	given in Part I.	1Y 24a. Wa aut	es 2 N s an opsy	o 3 Pro	
ecords, P. (he law requires that are has been signed and be despected by the law beauth he despected by the law law law law law law law law law law	<u>۾</u>		and girthe c	underlying cause	given in Part I.	1Y 24a. Wa aut	es 2 N s an opsy formed?	o 3 Pro	bably 4 Unknown utopsy findings available completion of cause of
Records, P. (nr. The law requires that rifficate has been signed on range 2 should be de-	Completed by	25. Was case referred to medical	uning in the c		given in Part I.	1	es 2 N s an opsy formed?	o 3 Pro 24b. Were a prior to death?	bably 4 Unknown utopsy findings available completion of cause of
Tital Records, P. (sician: The law requires this is certificate has been signed reporter and 2 should be the decired and 2 should be the decir	Be Completed by	examiner? Hospital: Innationt 2 4 5		26.Plac	ce of Death (Check	1 Y 24a. Wa aut per 1 Yes only one)	es 2 N s an opsy ormed? 2 No	o 3 Pro 24b. Were an prior to death? 1 Y	utopsy findings available completion of cause of es 2 No
of Vital Records, P. P. Physician: The law requires the er this certificate has been signed and director, mans 2 should be the districtor and 3 should be the districtor.	To Be Completed by	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 V E	R/Outpatient	26.Plac t 3 DOA	ce of Death (Check	1 Y 24a. Wa aut per 1 Y Yes only one)	es 2 N s an opsy formed? 2 No	o 3 Pro 24b. Were as prior to death? 1 ✓ Y	utopsy findings available completion of cause of es 2 No
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		1	_ State	partment of Health and Mertificate of Death	ental Hygie	- L U U U	20584
			Registrar 1. Decedent's Name (First, Middle, Last)	Janouro or Dour.	2. Date of Death		3. Time of Death
	Physicia	an	Joseph Bowman		Month 27	Day Year	0503 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	- CO - C	4c. County of Death	
	Examin	er	Ranquissance Gardan 9	antonevilla		Baltin	more
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Onder 1 Year II Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthol	ace (State or Foreign
	Director		145-09-3603 1\(\text{\$\ext{\$\text{\$\text{\$\text{\$\text{\$\text{\$\ext{\$\text{\$\text{\$\ext{\$\text{\$\text{\$\text{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\text{\$\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\exititt{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\exititt{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\exititt{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\exititt{\$\ext{\$\ext{\$\ext{\$\ext{\$\ext{\$\exititt{\$\ext{\$\exititt{\$\exi	Mottins Days Flours Will.	11/01/19		Jersey
	p ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		11	Od. Inside City Limits
	arylar shov	_	Toa. State	Location			1 □Yes 2 □No
	Ba-f	Director	MD Baltimore Caton	sville 10f. Zip Code	100	. Citizen of What Coun	trv?
	with t		709 Maiden Choice Lane	21228		nited State	•
	172 hours after death with the Maryland Treturel; or Items 23e or 28e-f show pates! Everylater must be inclified at	Funerai		3. Was Decedent of Hispanic Origin? (Spe		14. Race - Americ	
	ter deal	F	Armed Forces? 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
936	urs al	þ	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 🌪 ☐ No Specify:		Specify: Whi	te
5-0036	2 ho	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G.	cedent's Usual Occupation ive kind of work done during most of work	na 161	b. Kind of Business/Inc	lustry
215	within 7 ene. then "r	nple	Elementary/Secondary (0-12) College (1-4or 5+)	a. DO NOT use retired)			
2121	filed wi Hygien other th	S		ief Financial Offic	er o (First, Middle, Mai	Manufactur	ing
pu	tal H d oth	Be	17. Father's Name (First, Middle, Last) Samuel Y. Bowman		e Deacon	iden Sumame)	
Maryland	2 should be filed withir and Mental Hygiene. is marked other then aumatic event, I're M	၉	Commercial Commercial	ailing Address (Street and Number or Rura		Situar Town State 7in	Code)
Mar	12 sh h and 7 is n traun	Ì					
	s 1 and 2 should be filed within 72 hr if Health and Mental Hygiene. item 27 is marked other then "netu other traumatic event, It a Medical		Jacquelyn C. Campbell (Daughter) 1020a. Method of Disposition 20b. Place of Disposition	JU FeII Street, Apt sposition (Name of	. #210 Ba Date 20	LT.IIIICTE M c. Location - City or lo	D 21231 wn, State
5	0 0		1X Burial 2 ☐ Cremation 3 ☐ Removal from State	rematory or other place)		phrata, PA	
Baltimore,		H	' 4 Øonajon 5 ☐ Other (Specify) Cedar H. 21. Signature of Funeral Service Licensee	A- 10			
Ba	permit. Departr Importe eny inje		1 - 1 (Said	4107 Wilkens Avenue	opard fun e. Baltim	eral Home, pore. Marvi	inc. and21229
			23a. Part1. Enter the disease, or complications that caused the death. Do not				Approximate Interval Between
B	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	10000			Onset and Death
7	/Medical		disease or condition resulting in death) a Due to (or as a consequence of):	s discose			reac
н	Examiner		Sequentially list conditions b.				
11/	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
1/2	and and I-trans	Examiner	that initiated events c.				
30,	ate be executed hysician and the burial-transit	ũ	resulting in death) Last Due to (or as a consequence of):				
8760	cate be ex ohysician the burial	dicai	d				
9	ding I	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	12.00		23d. Date of delive	NO.
Вох	The law requires that the death certifics the has been signed by the attending phoage 2 should be detached for use as the	Completed by Physician/Me	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
o.	the de	ysic	1 Yes 2 No 9 Unknown				
<u>α</u>	that the	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	cco use contribute to th	ne cause of death?
ds	luires than signed I	q p			1 ☐ Yes	2 ☐ No 3 ☐ Prob	ably 4 Unknown
Records,	w requir been si should	jete			24a. Was an	24b. Were auto	psy findings available
Re	he la e has age 2	шо			autopsy performe 1 ☐ Yes 2 ☑	ed2 death?	npletion of cause of
Vital	en: Tifical	a	25. Was case referred to medical	26. Place of Deat	h (Check only one)		
\geq	Physicien: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	itient 3 DOA Other: 4 Jursing Ho	me 5 Residenc	ce 6 Other (Specify	v)
Jo r	ding Physicien: The lar h. After this certificate has funeral director, page 2		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) Inju		28d. Describe how	injury occurred	
<u>Ö</u>	Attending r death.	atic	2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	r Atto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stree City or Town,	et and Number or Rura State)	il Route Number,
	vital or urs af	Ce				(-)	
	Hosp 14 hou Fune Fune	edical	29a. Certifier (Check only one) (Check o				
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,	Day, Year)
	₹ <u>₹</u> ₹ 8		14.21-	77000			2006
	· V		30. Name of address of person who completed cause of death (Item 23a) (Ty	D30989	- L	2002 67 9	
	30.		Mula Carpenter Charles	Stown Medica	ol Cer	nter	
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Regist	rar	JUN 3 0 2006 Brown &	parke			

DHMH 17 Rev 1/2001

ORIGINAL

Amend Items 23a.PtI,II,25,27,28a-f per ME, G856,06/29/06dhb 1 - For A State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 April 10, Edna Ruth Bailey **Physician** 45 PM /Medical 4a. Facility Name (If not institution, give street and number)
Manor Care Woodbridge Valley 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Catonsville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth
July Pay, Year 23 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 🖫 F Missouri 495-30-5327 82 Yrs Director Usual Residence of Decedent the Maryland 10c City Town or Location 10a State 10h County 10d. Inside City Limits wohe 27 is marked other then "natural", or Iteme 23a or 28a-f elvor treumatic event, the Modical Exott har must be notified at MD Baltimore Lansdowne 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 U.S.A. 924 Catawba Ct. Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 end 2 should be filed within 72 hours after c nent of Health and Mental Hygiene. snt: if item 27 is marked other then "naturel", or Iter 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name *(First, Middle, Last)* Leonard Herman Looney 18. Mother's Name (First, Middle, Maiden Sumame)
Louella Bartee Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: if item 27 is any injury or other tret once. Albert J. Bailey/ Husband 924 Catawba Ct. Lansdowne MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ♣ Burial 2 Cremation 3 Removal from State John's Cemetery 4-13-2006 Ellicott City, MD 4 Donation 5 Other (Specify) 22 Name and Address of Facility Ambrose Funeral Home of Lansdowne 21. Signature of Funeral Se 2719 Hammonds Ferry Rd. Lansdowne MD 21227 23a. Part + Enter the disease, or compilications that caused the dishock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ath Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner LEXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a c Examine and I-transit The law requires that the death certificate be executed CERTIFICA Due to (or as a consequence of): attending physicien a Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) the a Records, P.O. 9 Unknown Š signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Ateriosclerotic cardiovascular disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 211146 2 No 1 🗌 Yes 1 TYes **Division of Vital** To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 24 Hospital: Other: ٩ 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) inis After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Accident 5 Pending death. 1 Yes X No Numerous falls investigation 03/2006 Unknown M Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, δ within 24 hours after To the Funerel Direc 4 Homicide 924 Catawoa Court, Lansdowne, at home MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) on 129769
6 N. Kelling Ld Buth ho completed cause of death (fem 23a) 30. Name and address bit berson w Day, Year) 6 vene 31. Date filed (Month. State JUN 2 9 2006 Registrar

06-04516 Kel

Please Type or Print in Black Indelible Ink

Kelly Boughter	1- For State	Department of Health and Ment Certificate of Death		2006 2058
Physician/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month June 27, 20	3. Time of Death
Medical Examiner	Ke11y Boughter 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of		4c. County of Death
	2210 Baltimore Avenue	Ocean City		Worcester
Funeral Director	180-76-5206 _{1 M 2 KF}	n yrs. last birthday) If Under 1 Year If Under 1 1 Year If Under 1 Year If Und	Min. Nov • 4,	1995 Porting Page (State or Foreign Country) PA•
d de any	Usual Residence of Decedent 10a. State	c. City, Town or Location Lebanon		10d. Inside City Limits 1 Yes 2 No
n with the Maryland ms 23a or 28a-f show be notified at once. eral Director	10e. Street and Number 2012 S. 5th Ave.	10f. Zip Code 17042	10	g. Citizen of What Country? USA
r death	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	If Yes, specify Cuban, Mexican,		14. Race - American Indian, 8lack, White, etc. White Specify:
5-0036 de within 72 hours afte de within 72 hours afte other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT u	ind of work done use retired)	16b. Kind of 8usiness/Industry
-003 d withing giene. There the withing the control of the control	17. Father's Name (First, Middle, Last)		Name (First, Middle, M	aiden Surname)
21215-0036 und be filed within 7 Mental Hygiene marked other than cevent, the Medise for Be Comple	Patrick J. Boughter		onne M. Gog	
MD 21 d 2 should lith and Me m 27 is ma numatic ev	19a. Informant's Name/Relationship (Type, Print) Yvonne M. Boughter/Mother	19b. Mailing Address (Street and Numb 2012 S. 5th Ave.		
Baltimore, N permit. Pages I and Department of Health Important: If item injury or other trau	20a. Method of Disposition 1	20b. Place of Disposition (Name of cemetery, crematory or other place) Friedens Mamorial Park	July 3, 2006	20c. Location - City or Town, State Myerstown, PA
Baltii permit Departm Importa injury o	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Charles L. St 1501 Fast Fo		ral Home Inc.
Physician	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	e death. Do not enter the mode of dying, such as ca	rdiac or respiratory arres	st, shock, or heart Approximate Interva 8etween Onset and
/Medical Sxaminer	Immediate Cause (Final disease or condition resulting in death) a. Carbon Monoxide Due to (or as a consequence)			Death
ited Insit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
nnd trransit	events resulting in death) Last Due to (or as a consequence of the co	uence of):		
760, cate be executed physician and the burial - transit	UNPENDED AMENDED			
ox 687 with certification of the second of t	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 23c. If yes, outcome 1 Live birth 4 Pregnant at tin 9 Unknown	2 Fetal death 3 Ectopic	pregnancy	23d. Date of delivery Month Day Year
P.O. Bc ss that the des gned by the a ce detached fo		ut not resulting in the underlying cause given in Par		pacco use contribute to the cause of death?
ds, P equires the consigner of the decorate of			1 Yes 24a. Was a	
Records, The law requirer froate has been sig			autops perforr 1 Yes 2	med? death?
tal Rician: Ti certifica	25. Was case referred to medical	26 Place of Death (Check only one)	
of Vitt Physic Per this eral dire	1 Yes 2 No Inpatient 27 Manner of Death	28b. Time of Injury 28c. Injury at Work?		Residence 6 Other: Scene ow injury occurred
ion C tending eath tor: Aft the fun	1 Natural 5 Pending FOUND: 2 ✓ Accident Investigation Jun 27, 2006	FOUND: 1 Yes 2 1	No Subject inha	led fumes accidentally
Division of Vital Records, spiral or Attending Physician: The law requirement Director: After this certificate has been so filled in by the funeral director, page 2 should to Certification: To Be Completed Certification:	3 Suicide 6 Could not be determined	ry - At home, farm, street, factory, office building, etc	or Town, St	treet and Number or Rural Route Number, City ate) tel- 2210 Baltimore Avenue, Ocear
Division of To the Hospital or Attending Physitin 24 hours after death To the Funeral Director. Aftert completely filled in by the funeral Medical Certification: T	29a Certifier (Check only one) 2 Medical Examiner: On the basis of exami	knowledge, death occurred at the time, date and pla- nation and/or investigation, in my opinion, death occ	ce, and due to the cause	e(s) and manner as started.
To wid	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
0,1	30. Name and address of person who completed cause of dea	O.C.M.E.		June 28, 2006
3	Jack Titus MD. Deputy Chief Medical Exa	aminer 111 Penn Street, Baltimore, M	MD 21201	
State Registra	[[]] [] [] [] [] [] [] [] [] [] [] [] []	signature Angels		
DHMH 17 Rev 1/2001		ORIGINAL		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Patrick Boughter

amen Boughto.	1- For State Registrar	ertificate of Death	Reg. No. 200	6 2058
Physician/	Decedent's Name (First, Middle,Last)	r	2. Date of Death Month Day Year	3. Time of Death 1400 hrs
Medical Examine	Patrick Boughte 4a Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	June 27, 2006 4c. County of Deat	
	2210 Baltimore Avenue	Ocean City	Worcester	
Funeral Director	196-62-0614 _{12 M 2 F} 40	s. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min. No. 1 1065 Fore	rthplace (State or gn PA • puntry)	
fun		ity, Town or Location		10d. Inside City Limits
nd show a	PA. Lebanon	Lebanon		1 Yes 2 No
the Maryland na or 28a-f show any piffied at once. Director		10f. Zip Code 17042	10g. Citizen of What Cou USA	intry?
215-0036 be filed within 72 hours after death with the Maryland natal Hygiene riked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Re Completed by Funeral Director	3 Widowed 4 Divorced in test Give Teat	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No specify:	Rican, etc.) White, etc. White, etc. Specify:	rican Indian, Black,
5-0036 ed within 72 hours. tygiene other than "natur: the Medical Exami	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+) 12	during most of working life. DO NOT use retii Welder	Farm Equ Manufac	ipment
21215-0036 Juld be filed within 7 Mental Hygiene marked other than re event, the Medics	77. Father's Name (First, Middle, Last) Francis J. Boughter	18.Mother's Name Rosem	(First, Middle, Maiden Surname) ary Althouse	
T. 28 8 5 1 6	J	19b. Mailing Address (Street and Number or F	tural Route Number, City or Town, Stat	e, Zip Code)
O 48 g 2 g	Yvonne M. Boughter / Wife	2012 S. 5th Ave. Le		- T C4-1-
Baltimore, MD 2 bernit Pages I and 2 shou Department of Health and Minportant: If item 27 is nijury or other traumatic	1 Burial 2 Cremation 3 Removal from State 4 Donarton 5 Other Specify:	Friends Memorial Park 200	y 3, Myaretan	
Baltimo permit Page Department of Important:	21. Signature of Juneral Service Licensee	22. Name and Address of Facility Charles L. Stevens Ft	meral Home Inc.	
Physician	23a. Part I. Enter the disease, or complications that caused the de failure. List only one cause on each line.	1501 Fast Fort Ave Bath. Do not enter the mode of dying, such as cardiac o	r respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Carbon Monoxide Int			Death
100	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause	se of):		
vecuted n and transit		e of):		
: a a a	UNPENDED AMENDED			-
Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be reached that a Director. After this certificate has been signed by the attending physicaled in by the funeral director, page 2 should be detached for use as the burning at the burning at the page of t	IF FEMALE: 23c. If yes, outcome of p 1 Live birth 4 Pregnant at time of 9 Unknown Part II. Other significant conditions contributing to death but n	2 Fetal death 3 Ectopic pregna	23d. Date of delive Month	ry Day Year
D. E	Part II. Other significant conditions contributing to death but n	ot resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	
S, P. uires thuires thuises the signer of th			1 Yes 2 No 3 Pro	utopsy findings available
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death completely filled in by the funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as			autopsy prior to death? 1 Yes 2 ✓ No 1 1	completion of cause of
ician: ician: s certifi rector.	25. Was case referred to medical examiner? [Hospital: 1] lengticet 2	26.Place of Death (Check ER/Outpatient 3 DOA Other Nursin	only one) ig Home 5 Residence 6 ✔ Oth	er: Scene
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate I completely filled in by the funeral director, page	27 Manner of Death 28a Date of Injury	28b. Time of Injury 28c. Injury at Work? FOUND: 1 Yes 2 ✓ No	28d. Describe how injury occurred Subject inhaled fumes accide	
Divisior To the Hospital or Attend within 24 hours after death for the Funeral Director; completely filled in by the	Natural 5 Pending Investigation 3 Suicide 6 Could not be determined Specify) Hotel/M	At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Ror Town, State) Days Inn Hotel- 2210 Baltimo	
the Hospi thin 24 hou or the Funer	Check only 1 Certifying Physician: To the best of my know	vledge, death occurred at the time, date and place, and on and/or investigation, in my opinion, death occurred a		
¥343	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed <i>(M</i> June 28 , 2006	onth, Day, Year)
	30. Name and address of pg son who completed cause of death (Jack Titus MD. Deputy Chief Medical Exami		1201	
Sta	te 31. Date filed (Month, Day, Year) 32. Registrar's Sig	nature		
Registr	The second	the Aprile		
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		1	For State Registrar	State of M	laryland		artment tificate			and M		giene Reg. No.	006	20588	
			Decedent's Name (First, Midd)	le, Last)							2. Date of De. Month	ath Day	Yea	3. Time of Death	
	Physicia		ANNA				SECK	E.2			JONE	24	200		
	/Medic Examin	_	4a. Facility Name (If not institution	n, give street and number	r)				Location of	of Death		4c.	County of D	eath	
			JOHNS HOPKINS	BAYVIEW CA	RE CE	NTER	BAL	TIM	ORE			BA	LTIMO	RE CITY	
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. la	ist birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da	th y, Year)	9. 1	Birthplace (State or Foreign Country)	7
	Director		215-16-6129	1□M 2 X F	85	Yrs.					April April	7, 19	921	Country) Maryland	
	od ≯		Usual Residence of Decedent 10a. State 10b. County	,	10c. City.	Town or Lo	cation							10d. Inside City Limits	
	sho	5	Maryland N/					timo	סתו					1 Yes 2 □ No	
	28a-f	ု ပ	10e. Street and Number				10f. Zip					10g. Citiz	zen of What	Country?	_
	72 hours after death with the Maryland Insturet, or items 23e or 28e-f show dical Examilher must be invilled at		434 Oriole A	lvenue					1224				u.s.	Α.	
	ns 23	Funerai	11. Marital Status	12. Was Deceder		S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.))- 1		American Indian,	_
10	riter	Fur	1 Never Married 2 Mar	ried 1 Yes 2			it Yes, spec 1 ☐ Yes 2		n, Mexicar Specify:		Hican, etc.)		Specify:	vhite, etc. White	
21215-0036	ret, o	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates	s:		10 105 2	24 140	эрөспу.				Specify:	wille	
5-0	72 hours neturel',	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		(Give	dent's Usua kind of wor	k done d	luring mos	t of workir	ng	16b. Kir	nd of Busine	ess/Industry	
21	ithin Ban	idu	Elementary/Secondary (0-12)	College (1-4o	r 5+)		_{DO NOT us} memak)				Ou	vn Home	
2	filed within Hygiene. other than ent, ite was		17. Father's Name (First, Middle,	/ act)		110	memur	ei.	18 Mothe	er's Name	(First, Middle	Maiden		on nome	_
Maryland	otal H ed ot	Be		cott						Anna	Woi		,		
7	2 should be and Mental is marked of sumatic even	၉	19a. Informant's Name/Relations			19b. Maili	ng Address	(Street a	and Numbe	er or Rura	I Route Numb		Town, Stat	te, Zip Code)	
Z	and 2 state of the contract of		Charles Becker	r (son)		1104	5 Dor	sch	Farm	Rd.,	Ellic	ott	City,	MD 21042	
5	s t and 2 f Health item 27 i		20a. Method of Disposition		20b. Pla	ace of Dispo ametery, crea	osition (Nam	ne of ther plac	e)	D	ate	20c. Lo	cation - City	or Town, State	
E	Page nent o nt: If ry or		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3	Specify)						6/29	/2006	Balt	imore	, Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netun any injury or other treumatic event, Ite Madical ODCe.		21. Signature of Furnital Service	whit.		3	2. Name and 331 B	d Addres re.hn	ss of Facili	y Sch	imunek Baltimo	Fune re. 1	ral H MD 212	lomes 213	
			Qua. Part 1. Enter the disease, of	or complications that caus	ed the death									Approximate Interval Between	
	Pnysician		m Jiate Cause (Final	t onty one cause on each										Onset and Death	
	/Medical		tises se or condition the liting in death)	a. TNEU Due to (or:	as a consequ										
	Examiner		Convention list conditions	b. CHEON	1C 0	DSTE	UCTI	VE	PULL	2000	ARY I	DIZE	ASE	2-DYEARS	S
	D ≅	ner	Sequentially list conditions, if any, leading to immediate	Due to (or a	as a consequ	ience of):									
	ite be executed lysician and ne burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ	ianca of):			_					=	
760,	be ex ician burial	cai E	,	0.00 10 (0.0	20 2 000040	31.00 0.7.								11	
687	phys phys the			d											
Box (eath certificate be executed attending physician and for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnar		⊒Ectopic pr	oonanov	,			2	23d. Date of		
	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as t	Physician/Med	in the past 12 months? 1 Yes 2 No		at time of de		Other (sp					4	Month	Day Year	
P.0	at the	Phy	9 ☐ Unknown Part II. Other significant condit	fane contributing to death	a but not recu	ulting in the I	indertying c	alice div	on in Part i	ı	23e. Did t	tobacco u	se contribut	te to the cause of death?	_
Ś	ires tha signed d be det	b		SEASE OS						••		Yes 2		Probably 4 Tunknown	١
orc	w require been si shoutd I	etec	1 10 2	102	(60,10				<u></u>		24a. Was	20	24h Ward	e autoney findings available	a
Records,	sician: The law certificate has b irector, page 2 s	Completed	<u> </u>								auto perfe	psy ormed?_	prior deat	e autopsy findings available to completion of cause of h? Yes 2 WNo	
Vital	ificate or, pa	Ö	25. Was case referred to medic	al					26. Place	e of Death	1 Tes	2 ☑√No one)		163 202110	_
>	Physician: r this certific ral director,	To B	examiner? 1 Tes 2 No	Hospital:	atient 2 1	ER/Outpatie	nt 3 DC	Oth	er: 4 ☐ Mi	ursing Ho	me 5 Resi	idence (6 □Other (5	Specify)	
10	ding Physician: n. After this certific funeral director,		27. Manner of Death	28a. Date of I	njury Day Ye <i>ar)</i>	28b. Time of	of 2	8c. Injun	y at k?		28d. Describe	how injur	y occurred		Ŧ
Ö	Attending or death.	atio	Z Accident	tigation			М		Yes 2 🗆						
Division of	after de Directo	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 286. Place of	Injury - At ho etc. (Specify	me, farm, st	reet, factory	, office			28f. Location (City or To			r Rural Route Number,	
	To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical C	29a. Certifier 1 Certify (Check only 2 Medice	ing Physicien: To the be of Exeminer: On the basis and manner	s of examinat	wledge, dea tion and/or in	th occurred nvestigation	at the tir , in my o	ne, date a pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) date and	and manne place, and	or as stated. due to the cause(s)	-
	Fo the vithin or the comple	Me	29b. Signature and title of certif	ier			290	c. Licens	e number			29d. Dat	e signed (M	fonth, Day, Year)	
			10. 11.	anan M.			D	00	631	64		JUN	E 2	6,2006	
10	1		30. Name and address of perso	n who completed cause of	of death (Item	23a) (Type	, Print)							2122	.4
W	10		ANIRUDH SE	DHARAN	550	3 H	OPKIN	S I	SAYVI	E W	CIRC	LE	BALT	IMORE, MD	
		ate	31. Date filed (Month, Day, Yea	(r) 32. Reg	istrar's Signa	ture	book	,						11MOZE, MD	
	Regist	rar	JUN 3	0 2006	GARD S	S P	9,00								

ettending physicien and for use es the burial-transit Box 68760 P.O. Division of Vital Records,

Funeral

Director

the Medical Examiner must be notified at

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permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If Item 27 ie marked other than eny Injury or other treumatic event, the Me

Physician

/Medical Examiner

altimore, Maryland 21215-0036

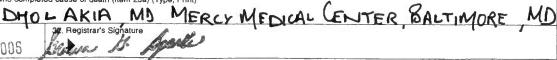
To the Hospital or Attending within 24 hours efter death. To the Funerel Director; After

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JUN 3 0 2005

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

29c. License number

D0063326

29d. Date signed (Month, Day, Year)

			For State of Marylan	d / Department of Health and N Certificate of Death	Mental Hygier	7000 70000
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia	an		BEVINS	Chambers A	Day Year 12 46 PM
	/Medic		KENNETH 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	June 2:	4c. County of Death
	Examin	er	The Talana Harallina Haralt	1 17 11	1	NA
_			5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	
	Funeral		102M 2□F /	Yrs. Months Days Hours Min.	Tebrucary 1,1	9. Birthplace (State or Foreign Country) 9. With place (MI)
	Director		Usual Residence of Decedent		reswany 1,1	146
3	0 M			y, Town or Location		10d. Inside City Limits
į	s 1 and 2 should be filed within /2 hours after death with frie maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If marked other than "natural", or Itams 23a or 28e-f show other traumetic event, the Medical Examinar must be notified at	ō	MD N/A	Baltimore		1 Pres 2 □ No
4	286	Funeral Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
3	a or	<u> </u>	4949 Edgemere Avenue	21215		12510
ŧ	98 23	era	11. Marital Status 12. Was Decedent Ever in U.	S 13 Was Decedent of Hispanic Origin? (St	pecify Yes or No-	14. Race - American Indian,
	Itari	5	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
ָ ק	/z nours affer 'natural', or Ite dical Examina	by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: AFMENW
3	tura	pa	15. Decedent's Education	16a. Decedent's Usual Occupation	16b	. Kind of Business/Industry
2	n /2	Completed	(Specify only highest grade completed)	(Give kind of work done during most of work life. DO NOT use retired)	king	
4	within ene. than the	Ē	Elementary/Secondary (0-12) College (1-4or 5+)	Title Lawyer		SUK
7	Hygiene. Dther thar ent, the N		17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	
Ξ.	tail h	Be		io. Modificial		
7	Men Men Merka Merka Menk	ျ	unk		McCre	
0	and and ls m		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Ru		
2	and and a library in 27		Edward Smith JR. Esyloundin		+ Balto	mone Mb 21218
בַּ	of He		Zoa: Montos of Bioposition	emetery, crematory or other place)		. Location - City or Town, State
= .	Pages net of int: If It iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	3 ac I Remotory Jone	24.2004 1	Saltmore 40
aithrio	orta inju		21. Signature of Funeral Service Lipensee	22. Name and Address of Facility	- /	1 6 2 2
Č	permit. Pages Depertment of Important: If I eny injury or one		Hot -	3 ay Zhendony Jone 22. Name and Address of Facility Hari D-Close 5126 3 e lain	- Funeral	Service P.A.
		_	23a. Part1. Enter the disease, or complications that caused the deat			Approximate
			shock, or heart failure. List only one cause on each line.	C s	or respiratory arrest,	Interval Between Onset and Death
, F	hysician		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)	VANCY of lung		2 months
΄,	/Medical		resulting in death) Due to (or as a conseq	uence of):		
	Examiner		Sequentially list conditions, b.			
	V -	ner	if any, leading to immediate cause. Enter Underlying	uence of):		
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events c.			
2	exe an ar rial-t		resulting in death) Last Due to (or as a conseq	uence of):		
0/9	death certificate be executed e attending physician and of for use as the burial-transit	dical	d			
9	ficate g phys	edl				
×	ding se s	Iclan/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregna			23d. Date of delivery
POX	atter for 1	clar	in the past 12 months?			Month Day Year
	the d	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown			
7.	w requires that the death certific been signed by the attending p should be detached for use as	Physl	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in Part I.	23e. Did tobaco	to use contribute to the cause of death?
က်	ngis bed	þ			1 ☐ Yes	No 3 Probably 4 □Unknown
ecord	neen s	ted				27(10 0) 1 10 10 10 10 10 10 10 10 10 10 10 10 1
a	K 02 C/	pie			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
_	The I	Completed			performed 1☐ Yes 25	death?
VII	ilcien: Th certificete rector, pag	0	25. Was case referred to medical	26. Place of Dea	th (Check only one)	
>	yslcien: is certific director,	To B	examiner? 1 Yes 2 No Hospital: 152 Inpatient 2	ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence	e 6 □Other (Specify)
ō	y Phys or this oral di		27. Manner of Death 28a. Date of Injury	28b. Time of 28c. Injury at	28d. Describe how in	njury occurred
0	Attending Physicien: r death. ector: After this certific by the funeral director,	10	Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury Work? M 1 Tyes 2 No		
Division	Attendii death. ctor: A y the fu	fica	3 Suicide 6 Could not be 28e. Place of Injury - At h	ome, farm, street, factory, office		and Number or Rural Route Number,
=	5 # 5 ⊆	Certification:	4 Homicide determined building, etc. (Specif	(y)	City or Town, Si	
	To the Hospitel within 24 hours a To the Funaral (completely filled	ŭ	29a. Certifier SC Certifying Physician: To the best of my kno	wledge, death occurred at the time, date and place	and due to the carre	a(s) and manner as stated
	Hos Fun Fun tely	edical	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.	tion and/or investigation, in my opinion, death occu	rred at the time, date	and place, and due to the cause(s)
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifier	29c. License number	704	Date signed (Month, Day, Year)
	S D M		D M a - A O A /		290.	1
•			KBEERU 94 191	KES-00	NO S	HNE EL, 2006
	4		30. Name and address of person who completed cause of death (Iter	n 23a) (Type, Print)	BALT	IMORE, ML 21287
			RBeckOld MD 30. Name and address of person who completed cause of death (Item ROSHelle BECKW17H, MD	JOHNS HOPKINS HOSPITAL	, buu iyort	H WOLFE STAFET
	Sta	ate	31. Date filed (Month, Day, Year) JUN 3 0 2005 32 legistrar's Signa	Huro		
	Regist	rar	JUN 3 0 2005 James &	T BOOKED		

			For State Registrar	St	ate of M	1arylan		artment rtificate			nd M		Reg. No.)6	20591
	Physicia /Medic	al	1. Decedent's Name (First, Midd				Bu	-400				2. Date of De Month	Day 20	Year OG	3. Time of Death
	Examin	er	4a. Facility Name (If not institution	Signie	D Com	ve co		~~	Itim	2010	2		4c. County	100	
	Funeral Director		5. Social Security Number 219–32–8581	6. Sex 1 ☐ M	20 7. /	Age (In yrs. I	last birthday) Yrs.	If Under 1 Months		If Under 2 Hours	Min.	8. Date of Bir (Month, Da Feb. 2	y, Year)	9. Birthp Cour Md.	lace (State or Foreign ltry)
	show	5	Usual Residence of Decedent 10a. State 10b. Count Md. Bal	timore			y, Town or Lo						· · · · · · · · · · · · · · · · · · ·	1	0d. Inside City Limits 1 ☐ Yes 2 🕱 No
	with the N s or 28a-f be notified	Direct	10e. Street and Number 8100 Longpoin					10f. Zip (2122	2		10g. Citizen of V	Vhat Cour	ntry?
36	within 72 hours after death with the Maryland lien. Jen And - A	by Funeral Director	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	12. W	/as Deceder med Force: ☐ Yes 2 ☐ Yes, Give 'ear or Dates	s? XNo		Was Decede If Yes, speci 1 Yes 2	ent of Hisp fy Cuban,			cify Yes or No Rican, etc.)	14. Rac Blac	e - Amend k, White, white,	
21215-0036	within 72 ene. than nat	Completed	(Specify onfy high Elementary/Secondary (0-12)		n npleted) college (1-4o	or 5+)	(Give life.	dent's Usual kind of work DO NOT use	k done du e retired)	ion ring most	of workii	ng	16b. Kind of Bu		dustry
73	be filed ntal Hyg od othe avent,	To Be Co	12 yrs. 17. Father's Name (First, Middle Charles Har				CI	SI IOUI			r's Name nna	(First, Middle	, Maiden Suman		
	d 2 sh th and 7 ls m treum		19a. Informant's Name/Relation David Burton	ship <i>(Type, F</i> SC	-		8	1 Wise	a Ave	. Du	ndal	k Md. 2			
Baltimore,	5 ± 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify)	val from Sta	16	Place of Dispo emetery, cre /VIEW)	June	30 006	20c. Location - Balt		
Balt	permit. Pad Department importent: any injury once.		21. Signature of Fundral Service	QH.	n		C	110 Sc	y Fu ller	nera s Po	l Ho int	Rd. 212			
	Enysician /Medical Examiner		23a. Part/ Enter the disease, shock or heart failure. List immediate Cause (Final disease or condition resulting in death)	a	Due to (or	s a conseq					cardiac o	r respiratory a	20 10	tra	Approximate Interval Between Onset and Death
8760, ≪ ■	death certificate be executed e attending physician and dor use as the buriat-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d	Diat	as a hseq	uence of):	tus	and	Co	ist ,	iico b'c	202		Xear?
.O. Box 68	that the death certifical led by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown		f yes, outcon □ Live birth □ Pregnant □ Unknown	2 ☐ Feta t at time of d	death 3	⊒Ectopic pre ⊒ Other (spe						te of delive	ery Day Year
rds, P	quires that n signed b	by	Part II. Other significant condi	. /	uting to death	~	ulting in the o		ause given	n in Part I.			tobacco use cont Yes 2 No		ne cause of death?
I Records,	The law requires that the ate has been signed by th page 2 should be detache	Completed		- 1 A								24a. Was auto perf 1 Yes	psy ormed?	Were auto prior to co death? I Yes	psy findings available mpletion of cause of
f Vital	Physicien: The this certificate har ral director, page	To Be (25. Was case referred to medic examiner? Yes 2 No	al Hosp	ital: 12 Nppa	atient 2	ER/Outpatie	nt 3□ DO	Other	-		ne 5□Res	one) idence 6 □Oth	er <i>(Specit</i>	y)
ion of	ng ifter ine		Z Z Addidont	tigation	8a. Date of I (Month,	njury Day Year)	28b. Time of Injury	of 28	Bc. Injury a Work? 1 □ Ye	at ? es 2 □		28d. Describe	how injury occur	red	
Division	tel or Atters after de et Directo	Certification;	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	mined 2	8e. Place of building,	Injury - At h etc. (Specil	ome, farm, si	reet, factory	, office				(Street and Numb lwn, State)	er or Rura	al Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	(Check only 2 Medic	Il Examiner:		s of examina		nvestigation,	in my opi	nion, dea			cause(s) and ma , date and place,	and due to	the cause(s)
)	To T Com	2	29b. Signature and title electric	9	N		>	29c	License Do		8	3	June June		-
	5		30. Name and address of person	13 (3000	ons	4 0 0	1	က [ဲ]	5.13 Ral	5 l	ore 1	JD 2	122	٠ 4
	St Regist	ate trar	31. Date filed (Month, Day, Yea	["] 2006	Reg	istrar's, Signa	Sp	cole							•

Amend item#23a-b,PII (856,6/30/06 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 15 AM Emylon Weddell Bodt 200 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HARfORE HAVRE GRACE JE 1712 ENS MURSING Homz | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 28,1921 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F 504-12-7747 84 Yrs. Director South Dakota Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or itame 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Market Street 21078 HSA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: δ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien important: If Item 27 is marked other the any injury or other traumatic U/K U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lena (nmn) Sattler º Henry (nmn) Weddell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Lee Plummer / POA 309 Calvary Rd., Churchville, Maryland 21028 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Churchville, Maryland Smith Chapel U.M. Chr 06-27-06 21. Signature of Juneral Service Licensee McCamas Funeral Home, P.A. Cussell 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each 10 Diabetes 10 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ailure Pnysician /Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Vital Récords, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BOOT, Emylow 2/2/10 Failure to Thrive 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes No 1 🗌 Yes 20 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Netural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation **Director:** 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours e To the Funeral terifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Pay, Year) 29b. Signature and title of co 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 281 E. lain Jok hadde 31. Date filed (Month, Dav. Year) 32. Registrar's Signature State JUN 3 0 2006 Registrar

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			1 - For State Registrar	State of Ma	iryiand		tificate of			- 0	006	20593
	4		Registrar 1. Decedent's Name (First, Middle, La	st)			incate of	Dealli	2. Date of De.	Reg. No.	UUU	3. Time of Death
	Physicia		Oscar	Jerome			Butle	r	June	20	2006	2:40 a _M
	/Medic Examin		4a. Facility Name (If not institution, giv					or Location of Deat		T	County of Death	2.10
	LAGITIII		Genesis Nursin	a Home			LaPlat	а		Ch	arles	
	Funeral		Social Security Number 6. 5		(In yrs. la	ast birthday)	If Under 1 Year Months Days					olace (State or Foreign
l.	Director		216-40-8856	NEM ZUF	63	Yrs.			Decem			ýland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Maryi f sho	tor	Maryland Char	les	Bry	yanto	wn					1XYes 2□No
	r 28e	Director	10e. Street and Number	105		yanco	10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	23e o		6340 Sun Brook	Place			20617			US	A	
	ams	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	er in U.S	S. 13.	Was Decedent of I f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 1	4. Race - Ameri Black, White,	
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give	lo		1 ☐ Yes 2√☐ No				Specify: Bla	
8	72 hours after death with the Maryland natural', or Items 23e or 28e-f show dical Examinar must be notified at	ed b	15. Decedent's E	Year or Dates:		16a Dece	dent's Usual Occup	oation		16b Kin	d of Business/In	dustry
5.	n na	Completed	(Specify only highest gro	ade completed)		(Give	kind of work done DO NOT use retire	during most of wo	rking	100. 11.	G 01 24011100G11	
212	d within giene.	HO	Elementary/Secondary (0-12)	College (1-4or 5	+)	Main	tance			Foo	d Line	
pu	be filed within 72 hours after death with the Marylan Ital Hygiene. ed other than "natural", or Itams 23e or 28e-f show avant, the Medical Examinat must be notified at	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden S	Sumame)	
yla	should by ind Menta ind marked imarked	1º	Oscar DeSale	s Butl	er			Mary	M			enfield
Maryland 21215-0036	an an eu		19a. Informant's Name/Relationship (and Number or Ri				
	s 1 and if Health itam 27 othar tr		Mary Toye / Da	ughter	20b. PI			r. Apt	331 Wa.		t, Mary	
٥			1 Burial 2 ☐ Cremation 3 ☐				sition (Name of matory or other pla	1	1/2006			
Baltimore,			' 4 □ Donation 5 □ Other (Special Service Lice)		ISC.	. Mar	YS 2. Name and Addre	see of Equiliby				Maryland
Ba	permit. Departr Importa any inji		That G	2	191	1 20	605 Agu	Ac asco Ro	lams Fui	nera	I Home	PA and 20608
•			23a. Fart1. Enter the disease, or com shock, or heart failure. List only	pplications that caused	the death		_				riar j =	Approximate Interval Between
Į,	Physician		Immediate Cause (Final disease or condition	Thro	+	Ca	nces					Onset and Death
	/Medical		resulting in death)	Due to (or as			-02				1	
b	Examiner	_	Sequentially list conditions,	b								
	5 7 E	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Drease of injury	Due to (or as	a consequ	ience or):						
	sician and	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):						
760,	te be executed ysician and	calE		d.								
89			29.00									
Вох	death certificat e attending phy d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	v		2:	3d. Date of delive	
	0 0 0	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of de	ath 5	Other (specify)			1	Month	Day Year
P.0	that the de led by the a detached i		Part II. Other significant conditions	contributing to death by	it not resu	Iting in the u	nderhing cause on	ven in Part I	23e Did to	nhacco us	e contribute to t	he cause of death?
ds,	50 75 80	d by		g					10	∕es 2∑	X No 3 □ Prot	pably 4 □Unknown
Record	w require been sig should b	lete							24a. Was	an	24b. Were auto	ppsy findings available
Re	The lavate has	ompleted							autop perfo	sy rmed?	prior to co death?	mpletion of cause of
Vital		e C	25. Was case referred to medical					26. Place of De	1 ☐ Yes ath (Check only o	ay⊿No ne)	1 ☐ Yes	2 No
*	y s	To B	examiner? 1 □ Yes 2X No	Hospital: 1 Inpatie	nt 2 🗆 i	ER/Outpatier	at 3 DOA	ner: 4 Nursing H	Home 5 ☐ Resid	dence 6	☐Other (Specif	(y)
n of		* *	27. Manner of Death 1 ► Natural 5 □ Pending	28a. Date of Injui (Month, Day	Y Year)	28b. Time of Injury	Wo		28d. Describe I	now injury	occurred	
sio	Attending r death. actor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not to	20	411	, .		Yes 2□No	206 1	24		18-11-11
Division	or Attend after death Diractor:	Certification	4 Homicide determined	building, etc	. (Specify	me, rarm, str	eet, factory, office		City or Tov		Number or Hurs	al Route Number,
_	urs urs ara		29a. Certifier 124 Certifying P	hysician: To the best of	of my know	wledge, deat	n occurred at the ti	me, date and place	e, and due to the	cause(s) a	and manner as s	tated.
	To the Hosl within 24 ho To the Funs completely f	edical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examinat	ion and/or in	vestigation, in my	opinion, death occi	urred at the time,	date and	place, and due to	the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of contifier	0 00			29c. Licens	_	_	29d. Date	signed (Month,	Day, Year)
)	,		, run L	Tech	MD			5228	9		121	1255 6
	K		30. Name and address of person who				,					
	<u> </u>		Dr. Krishan Mai	thur 3500	Olo	Was]	ning ton	RD Wal	dorf,Ma	ryl	and 20	601
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician Yeer June 26, 2006 2:17 PM Louis Burkhardt /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center Baltimore Towson 8. Date of Birth (Month, Day, Year) May 4, 193 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 213-30-9031 74 Yrs. 1932 Pennsylvania Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itame 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 📉 No Director Maryland Phoenix Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14608 Woodbark Lane 21131 U.S.A. filed within 72 hours after death thygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1X Yes 2 No If Yes, Give 1953-1954 Year or Dates: or i 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman 12 Commercial Batteries permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any light or other treumstic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Jerome Burkhardt <u>Minnie</u> Shaffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Gwendolyn Burkhardt Wife 14608 Woodbark Lane Phoenix. Maryland 21131 20b. Place of Disposition (Name of cemetery, cremator or other place)
St. James Episcopal
Church Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7-1-2006 Monkton Maryland 21. Signature of Foneral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 | Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier 1)25205 15+1 and address of person who completed cause of death (Item 23a) (Type, Print) bolts and

Registrar

31. Date filed (Month, Day, Year) 2006

Rarles St. 32. Registrar's Signature

6701

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** BLUM JUNE 5:03 P. M MARGARET R. 27, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** HOSPICE OF BALTIMORE GILCHRIST CENTER BALTIMORE TOWSON If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth Month Day, Year) 10-15-1930 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M **X X** F 75 MARYLAND 216-28-2184 Yrs. Director Usual Residence of Decedent the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes XX No MD. BALTIMORE TOWSON Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ROAD 2103 WINDY GATE 21286 U. S. A. death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★★No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 □ Yes 2XX WHITE Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE CITY DEPT. Elementary/Secondary (0-12) College (1-4or 5+) YEAR permit. Pages 1 and 2 should be filed wit Department of Heelth and Mental Hygiene Important: If item 27 is marked other that any injury or other traumation. SUPERVISOR OF SOCIAL SERVICE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ROTH CLARENCE ANNA Μ. NEUBECK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type Print) DONALD J.BLUM, SR. (HUSBAND) 2103 WINDY GATE ROAD, TOWSON, MARYLAND, 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 07-01-2006 BALTIMORE, MARYLAND MOST HOLY REDEEMER 4 ☐ Donation 5 ☐ Other (Specify) 1050 YORK ROAD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 (R. G. RUTH) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death No epithelial CANCER Immediate Cause (Final disease or condition resulting in death) **Physician** ASTA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. physicien IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ò Month Day Year 5 Other (specify) detached ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an has certificate 2 No 1 ☐ Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 □ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 125205 June 28,2006 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) Charles St. Belts Md 2120X BMC 6701 2. Le 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 3 0 2006 Registrar

0			For State Registrar	State	of M	larylan	-	artmen rtificat				Mental Hy	giene Reg. No.	006	20596
X	Physicia		1. Decedent's Name (First, Middle									2. Date of De Month	_	Year	3. Time of Death
10	/Medica			er Boer				110 25				June		2006	12:00P M
	Examine	er	4a. Facility Name (If not institution Gilchrist Hos					_	Town, or OWSC	Location	of Death			inty of Death	
	- Francisco		5. Social Security Number	6. Sex			last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bi	rth		place (State or Foreign ntry)
3	Funeral Director		219-14-1210	1 ∑ M 2□ F		81		Months	Days	Hours	Min.	April	10 , 192	5 Mar	yland
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9	ith the Marylar or 28e-f ahow e notified at	Director	10e. Street and Number					10f. Zip	Code				10a. Citizen	of What Cou	ntry?
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9:112m	death	by Funeral	11. Marital Status	12. Was D	ecedent Forces	t Ever in U	.S. 13.	Was Deced	dent of Hi	ispanic Or	igin? (Sp	ecify Yes or N Rican, etc.)	o- 14. I	Race - Ameri Black, White	
à K	or its	교	1 Never Married 2 Marr	ed 1 ☑ Ye If Yes,	s 2 □ Give r Dates:	No WW		1 ☐ Yes	_	Specify.		7110411, 010.7		acify:	
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25	d with giene r the	Completed	Elementary/Secondary (0-12)	College	1-4or	3+)	Engir	neer	LOIL	s sys	cens			NSA	
7	d oth	Be	17. Father's Name (First, Middle,									e (First, Middle		name)	
	J Men narka natic	၉	Carl Joseph		3		10h Meille		/C44			M. Rabe		Canan 7	- 0- 1-1
J. N. G	id 2 st ith an 27 is r traur	- 1	19a. Informant's Name/Relations Audrey Boenning)			•				Columbi			,
	S 1 ar		20a. Method of Disposition		,	20b. F	Place of Dispo cemetery, crei	sition (Nan	ne of	e)		Date	20c. Location	on - City or T	own, State
DENNI	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Depertment of Health and Maral Hygiens 1. The mortant is I flam 21 a marked other than "natural", or itema 23a or 28e-f ahow any injury or other traumatic avent, the Modical Examinational De notified all ORGE.		1 ☐ Burial 2 🖫 Cremation 4 ☐ Donation 5 ☐ Other (S		m State	,	etro Ci				6-30	-2006	Caton	sville	e, MD
0 3	armit. spertr sports sy inju		21. Signature of Funeral Service	Licensee			20	Name an	d Addres	ss of Facili	Hom	es, Ind			
ति ।	20559	-	1 4118 K	Hace	_VY	x								, MD 2	
			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause o	n each	line.	n. Do not ent	1				or respiratory a	irrest,		Approximate Interval Between Onset and Death
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	Examiner				io (oi a.	a conseq	derice or).								O
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507	ficate p phys ts the			d						-					
>	eath certific attending pl	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,		e of pregna		Ectopic pr	0.0000001				23d.	Date of deliv	ery
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	res thet the de signed by the a		9 ☐ Unknown Part II. Other significant condition		_	but not son	udting in the	a do shi ia a a		n in Don't		23o Did	John oon uso o	ontributo to t	he cause of death?
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	after Direct of in by	Certification;	4 ☐ Homicide determ	bu bu	ilding, e	tc. (Specif	(y)	out, ractory	, omoo			City or To	wn, State)	and or right	ar riodio ridinadi,
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	the H nin 24 the Fi nplete	Medical	one)	and m	anner s	tated.					- Occur	red at the time,			
	To To Con	~	29b. Signature and title of certifie	1 1	D.	. 1.	no						29d. Date sig		
	5		30. Name and address of person	who completed ca	aus	Death /Item	n 23a) (Type	Print)	0	, ,	-	4	rule	a 1,0	2006
	1-		(1) A-Ri	ey 6	31		670	I N.	Ch	al	es -	t. Ba	lto-1	nd c	2120/
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			1 - For State Registrer	State of Maryl	and / Depa		Health and M	∕lental Hygi	•	20597
	Physici	an	Decedent's Name (First, Middle, Last, Lois Baker					2. Date of Death Month June 28	Day Your	3. Time of Death 5:30p M
	/Medio Examin	al	4a. Facility Name (If not institution, give Montgomery General			4b. City, Town,	or Location of Death		4c. County of Death	
1	Funeral Director		5. Social Security Number 6. Sec 565-07-5874		yrs. last birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Dec 7,	Year) 9. Birth	place (State or Foreign intry) ifornia
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Montgo		. City, Town or Lo Silver	cation Spring				10d. Inside City Limits 1 ☐ Yes 2 X No
	with the	I Dire	10e. Street and Number 3452 Chiswick Cour	·t		10f. Zip Code	20906	10	Og. Citizen of What Cou U.S.A.	intry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if item 27 is marked other than "natural", or Iteme 23s or 28s-1 show amy injury or other traumatic event, Its Medical Examiliar manalibe metitied at ance.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	ĺ	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ▼ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	14. Race - Amer Black, White	
Maryland 21215-0036	within 72 hor ene. than "naturi re Medical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	DO NOT use retire	during most of wor	king	6b. Kind of Business/l	ndustry
yland 2	ould be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Howard Oxsen				Ruby F	ne (First, Middle, M	laiden Sumame) N	
re, Mar	s 1 and 2 shaft Health and Item 27 is m		19a. Informant's Name/Relationship (7) Jeannette Jefferie 20a. Method of Disposition	es (Daughter	736 (hessie C	rossing W	lay Wood	City or Town, State, Z.bine, MD 2.	1797
Baltimore,	mit. Page partment o portent: If y injury or ce.		1 ☐ Burial 2 【▼ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	M	etro Cre	ematory	6/3		Baltimore, me at MMP,	
	Physician		231 art 1. Enter the dise 1. or complement of the complement of th	is that caused the cause on each line.		7250 Wash ter the mode of dy	ington Bl	vd. Elk	ridje, MD :	21075 Approximate Interval Between Onset and Death
8760,	that the death certificate be executed ed by the attending physicien eraction of the attending physicien set of the attending physicien of the attending physicien of the attending the attending the attending the attending the attending the attending to the atte	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor Due to (or as a cor Due to (or as a cor Due to (or as a cor	nsequence of):	effi	SION			years on week 2 weeks
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Divis	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp.	pecify)			City or Town,		
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)	Veith To t	×	29b. Signature and title of certifier	VILL	70	29c. Licen	se number	29	d. Date signed (Month)	Day, Year)
•	, D		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Type,	Print)	0.00	201 . 44:	X = 1	20.32
	Sta Regist		31. Date filed (Month, Day, Year) JUN 3 0 2006	ompleted cause of death	igrature	18101	frince 1	hillip L	or Olnei	MD

		1	For State Registrar	State of	Marylan		artmen rtificate				lental Hy	giene Reg. No.	006	20598
			1. Decedent's Name (First, Middle, La	ist)							2. Date of De. Month		Year	3. Time of Death
	Physicia /Medic	an	MICH			A .		0	000	0	プリルド		200C	2:25PM
}	Examin		4a. Facility Name (If not institution, given	e street and numb	ber)		4b. City,		Location			4c. Co	unty of Death	
			Bon Secours Hosp	ital				Ba1	timo					
	Funeral			Sex 7. 1⊠M 2□F	. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Aug 17	th y, Year)	9. Birth	place (State or Foreign ntry)
	Director		214-72-8290	X W 201	46	Yrs.			l		Aug 1/	, 1959	Nort	h Carolina
	and *	}	Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Many	ō	MD			Po1	timor	^						1 ⊋Yes 2 □ No
	28a-	rect	MD 10e. Street and Number			Dal	10f. Zip					10g. Citizer	of What Cou	ntry?
	Sa or	Ö	123 S. Fulton Av	enue				21	223			US	A	
:	within 72 hours atter death with the Maryland ene	Funeral Director	11. Marital Status	12. Was Deced	lent Ever in U	.S. 13.	Was Deced			igin? (Spe	ecify Yes or No Rican, etc.)		Race - Amen	
ω .	riter of the control	Fu	1 Never Married 2 Married	Armed Ford	es? □No 1/1	8/77					Hican, etc.)		Black, White,	
9	ours a	۵	3 Widowed 4 XDivorced	Year or Dat	es: 2/2	25/77	1□Yes :	ZXI NO	Specify:			Sp	ecify: W	nite
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Baltimore, Maryland 21215-0036	permit. Pages 1 Department of I- Important: If ite any injury or ot ance.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Special		tate	emetery, crei	matory or o	ther plac	:e)					
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			30. Name and address of person who	completed cause	of death (Iter	m 23a) (Type	Print)	130	N =	SFZ	UVRS	20 12	sP.	
			SUDKIR	PAT	TE1	Z	0000	1 3	A 27	03	T, 13	ALTO	MD	, 21223
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	Regist	rar	JUN 3 0 2	UUU	BURGA J	J. Pal	-0-0-0							

State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death 2. Date of Death 3. Time of Death-1. Decedent's Name (First, Middle, Last) Year Crosby **Physician** ERRU 2000 81 H 27 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSPITAL HOPKINS Baltimore ary Johns If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs/last birthday) **Funeral** Days 1 X M 2 F Yrs Director March 22, 1958 Wan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le Inside City Limits 28a-f ehow other treumstic event, the Medical Examiner must be notified at 12 Yes 2 □ No Director MUC 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or items 23a or Funeral . Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□ Yes 20 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 Divorced "naturei" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life., DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr tore is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other then College (1-4or 5+) Elementary/Secondary (0-12) Lifts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame nosbo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Informant's Name/Relationship (Type, Print) State, Zip Code, Balto, ing, 012 ark hei Are Art A-B 21215 Howard 20b. Place of Disposition (Name of Date 20a. Method of Disposition 205 Location - City or Town, State permit. Pages 1
Depertment of H
Important: If itel
eny injury or oth 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature Puneral Service License complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Enter the disease, or com, or heart failure. List only and Death Immediate Cause (Final disease of condition resulting in death) Brain Injury Anoxic **Physician** days /Medical Due to (or as a consequence of) **Examiner** PSIS days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physicien Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No sete hes been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? res 2 No 2 🗆 No 1 Yes 1 Tes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1. Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Manual, Medical Doctor Res-000 June 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRIYA MAKADIA. The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Haryland 21287 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar JUN 3 0 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1 Per Phy G856 6/30/06 JH Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Month Year **Physician** Colongelo Michael Colangelo June 23 825P & GGS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner genezis 8. Date of Birth (Month, Day, Year) 1, 1916 Year If Under 24 Hrs. Perring Parkwey Center Social Security Number 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min 212-03-3910 1X M 2□ F 89 Months Hours New York Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, Ita Marical Ever it er must be resulted at 2008. 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Directo Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9009 Carlisle Avenue 21236 u.s.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Plumber Union Local 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Colangelo Domine.co Josephine Mistretta ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Colangelo 9009 Carlisle Avenue, Baltimore, MD (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Maus. · 4 Donation 5 DOther (Specify) Entombment 6/26/2006 Timonium, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Road, Baltimure, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** manu /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): physician a s the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 dhknown Completed 24b. Were autopsy findings available prior to completion of eause of death?

1 Yes 2 2 70 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 9 1 Yes 4 Nursing Home 5 Residence 6 □Other (Specify) tha Funeral Diractor: After the oppletely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: ☑Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within To tha

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of pertifie

31. Date filed (Month, Day, Year)

Heins

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

5601 Lock Raven BIVS#303POB

29c. License number

00059423

Bulmnere

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:00 P M MILDRED **Physician** COMBS 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BON SECOURS HOSPITAL 21773 BALTIMUNE MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 M 2 F Yrs. 213-18-9020 October 27,1916 MM Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Item 27 is marked other than "natural", or itams 23a or 28a-1 show other traumstic event, the Medical Examiner must be netitled at 1 THES 2 No Baltimore MD Director NIA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21230 2409 Wilgren Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene important: if Item 27 is marked other than "natural, or Itan any injury or other traumetic event, the Mudical Examiner page. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Aprilan 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Union menorial Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNK Charles Kan P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bultmore mo 21230 Court David Edwards Wilgrey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltmore Mys view Crematory `4 □ Donation 5 □ Other (Specify) - 25-06 22. Name and Address of Facility se Funera 21. Signature of Plun rai Service Licensee Re 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DECOMPENSATION Physician, a EUD STAGE CARDIAC /Medical Due to (or as a consequence of): CANDIO MYO PATHY **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit DISEASE The law requires that the death certificate be executed ARTEM COLDNARU Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANEMIA - THROMBOCH FO PENIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Janknown HYPERTENSION Completed DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 ☑ No s after dea... ral Director: After un-28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after des ne Funeral Directo 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3076 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD V. MOGHGELI

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 3 0 2006

22. Registrar's Signature

SAUTIMARE

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		- For State Registrar		Certif	icate of	Death		, ,	Re	g. No.	.UU	0 4000
Physici	an/	Decedent's Name (First, Middle, L Lamara	ast)		Che	erry		- 1	Date of Deat Month	h Dav Y	ear	3 Time of Death 0613 hrs
dical Exami	пел	4a. Facility Name (if not institution,	give street and number))		b. City, Town, o	or Location of		June 27, 2	4c. Count	of Deal	
		1100 block of Shields P	lace			Baltimore						
Funeral Director		,		e (În yrs. last 47		If Under 1 Ye Months Da	_	24Hrs. Min.		h(MM/DD/YY) 31–58	Forei	rthplace (State or gn N.C.
	H	Usual Residence of Decedent	XM 2 F	-17	Yrs.							ountry,
any	ŀ	10a State 10b. County			wn or Location							10d. Inside City Limits
Aaryland 28a-f show 1 at once.	칟	Md.	NA		Baltin	nore						1 Yes 2 No
21215-0036 Und be filed within 72 hours after death with the Maryland hental Hygiene marked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 1220 McCulloh	St., 3rd F	loor		10f. Zip Code 212			10	Og Citizen of V USA	Vhat Cou	untry?
with t ns 23a be not		11. Marital Status	12. Was Decedent			Decedent of H					ce - Ame	rican Indian, Black,
death or ite	Funeral	1 X Never Married 2 Marr	1 Yes 2	X No		es, specify Cuba		rueito Ki	carr, etc.)		D.	lack
after ral", o	ğ		or Dates:			Yes 2X N				Specify	/·	
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36 thin 72 than "	plet	12th grade	2 yrs.	34)	De:	livery				Var	cious	5
5-0036 iled within 72 Hygiene. I other than the Medical	Compl	17. Father's Name (First, Middle, La	ast)				18.Mother's	Name (F	irst, Middle, N	l 1aiden Surnan	ne)	
215 be file ntal Hy rked o	Be	Roosevelt		Cherr	cy, Jr		Lo	ttie			Haz	zel
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MD id 2 sho ilth and m 27 is aumati		Lottie M. Haze	1 Mother									ore, Md. 21
Baltimore, bermit Pages I an Department of Hea Important: If ite		20a Method of Disposition 1 Burial 2 Cremation	3 Removal from St		ce of Disposi matory or oth	tion (Name of o er place)	emetery,		Date		•	r Town, State
Page Page nent c		4 Donation 5 Other Spec	cify:	Gre		nt Cem.		7–3	-06 -			e, Md.
Baltimo permit Pages Department or Important: I		21. Signature of Funeral Service Li	censee			ame and Addre arch F.		. +-		e. Nort		Md. 21202
	-	23a. Part I. Enter the disease, of co	implications that saused	the death Do								Approximate Interva
Physician /Medical		failure. List only one cause or	each line.							ot, briodk, or r	iourt	Between Onset and Death
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ficate be executed the physician and the burial - transit	/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco							23d. Date		,
Box 68 death certification attending	Sian	past 12 months?	1 Live birth Pregnant a	t time of death		al death 3	sEctopic	pregnanc	ÿ	Month		Day Year
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ecc he lav ate har age 2	Completed		•						perfor		death?	′es 2 No
Rn: T entifica ttor, p	Be C	25. Was case referred to medical				26.Pla	ce of Death (Check on	ly one)			
Vita hysici this of 1 direct	0	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati		R/Outpatient	1				Residence 6		er Scene
of ing Pl After unera	l ii	27. Manner of Death 1 X Natural 5 Deading	28a. Date of Inj (Month, Day,	ury 28 Year)	8b. Time of Ir	· · _	ijury at Work?		Bd. Describe h	now injury occu	ırred	
ttend death tor:	atio	1 A Natural 5 Pendir 2 Accident Investi	gation				Yes 2	-	25 - 25-2			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. The Function of After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burit	Certification:	3 Suicide 6 Could 4 Homicide determ	not be	njury - At hom	e, farm, stree	et, factory, office	e building, etc	. 2	8f. Location (8 or Town, S		iber or R	ural Route Number, City
Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Phy	sician: To the best of n	ny knowledge,	death occur	red at the time,	date and pla	ce, and du	ue to the caus	e(s) and mann	ier as sta	irted.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Exam	iner: On the basis of exa and manner stated	amination and/	or investigati	ion, in my opini	on, death occ	curred at t	he time, date	and place, and	due to t	he cause(s)
F 3 F 3	18	29b. Signature and title of certifier	/ 1			29c. Lice	nse number			29d. Date sig	aned (Mo	onth, Day, Year)
		a side K	alla	n		0.0	C.M.E.			June 27,	2006	
n		30. Name and address of person w										
(3)			stant Medical Exa			Street, Baltii	more, MD	21201				
	tate			ar's Signature	-							
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	1 - State Registrar					artment of I tificate of				Reg. No.	ion to the to	
an	Decedent's Name (First, I OTTE	Middle, Last)				0.1	140.101		2. Date of D Month	eath Cay	Year	3. Time of Death
al	CHARLOTTE	9. al				4b. City, Town, o	APLAN	of Dooth	JUPE	10	250 County of Dea	
er	4a. Facility Name (If not inst	tution, give si	. 0	De Hin	1.150	0	we cocation	C	the	40. (oddiniy or Dea	N/A
	5. Social Security Number			Age (In yrs. Ia		If Under 1 Year	If Under		8. Date of B	lirth	9. Bir	thplace (State or Fore
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Director		IN/ A		DAL	TINORE	10f. Zip Code				10a Citia	zen of What Co	
Ë	10e. Street and Number 2903 FALLST	VEE DU	AD #E02			21209				rog. Citiz	U.S.	
Funeral	11. Marital Status		2. Was Decede		S. 13. \	Was Decedent of I	Hispanic Or	rigin? (Spe	cify Yes or N	No- 1	4. Race - Ame	erican Indian,
뎚	1 □ Never Married 2 🔀	Married	Armed Force		1	f Yes, specify Cub			Rican, etc.)		Black, Whi	vHITE
by	3 ☐ Widowed 4 ☐ Div	orced	If Yes, Give Year or Date	s:		1□Yes 2ŪNo	Specify:	:			Specify:	
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B	17. Father's Name (First, M	OOIO, LASI)				FORMAN			(I II SI, IMIOO	ie, ivialueii i	Julianiej	SHIFRIN
Tof	CHARLES 19a. Informant's Name/Rel	ationship (Tue	no Print)		10h Mailir	rukijan ng Address (Stree		PHIE	I Route Num	her City or	Town State	
	CHARLES CAP					FALLSTA						
	20a. Method of Disposition			20b. Pf	lace of Dispo	sition (Name of	1		ate		cation - City or	
	1 Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Ott		emoval from Sta	ate BET	H"JACC	B CONG.	109)	06/2	9/2006	FIN	KSBURG	, MD
	21. Signatur of Funeral Se		g	2.55	22	2. Name and Addr	ess of Facili	ity SO	L LEVI	NSON	& BROS	., INC.
	> Glan()	Vend	OUIN.									, MD 21208
	23a. Part1. Enter the disea	se, or compile	cations that cau	sed the death	n. Do not ent	er the mode of dy	ing, such as	s cardiac o	or respiratory	arrest,		Approximate Interval Between
ŀ	shock, or heart failure Immediate Cause (Finat	. List only on	OLA CAUSO OI BAC	. \ [5]	150	Hemit	7					Onset and Death
	disease or condition resulting in death)	a a	Due to (or	as a consequ		Memar	1					Scrace
	Commented to the second stance	ь										
ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying			as a consequ	Jenice of).							
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cian	23b. Was decedent pregna in the past 12 months			n 2 ∐ Fetal it at time of de		Ectopic pregnand Other (specify)	у	NI	A-	. '	Month	Day Year
ysic	1 ☐ Yes 2 ☐ 0 9 ☐ Unknown		9□ Unknow									MA
Y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							1.	23e. Did	d tobacco u	se contribute t	to the cause of death?
									No 3 □ P	robably 4 Unkno		
Completed			AIN	-					24a. W		24b. Were a	utopsy findings availa
E								-	pe	topsy rformed?	prior to death?	
0										1010	5 2/40	
0	examiner?	Н	ospital:	atient 2	ER/Outpatier	nt 3 DOA	her				Other (Spe	ecify)
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ျ	3 ☐ Suicide 6 ☐ 6	ome, farm, st	street, factory, office 28f. Location (Street and Number City or Town, State)						or Rural Route Number,			
ျ	4 Homicide			, etc. <i>(Specif</i>)								
				is of examina		h occurred at the vestigation, in my						
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State of Maryland / Department of Health and Mental Hygiene UUD

Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** David 4:25 PM DAWSON June 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Johns Hopkins Bayview Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 215-76-6303 48 Director Aug. 26, 1957 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified a once. 1 ☐ Yes 2 ☑ No Director Parkton Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1644 Bond Road 21120 U.S.A. Funerai 12. Was Decedenl Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Tes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HVAC Co. 12 years <u>sales engineer</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ William Henry Dawson Marie Grace Serio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1644 Bond Road, Parkton, Md. 21120 19a. Informant's Name/Relationship (Type, Print) Jennifer Dawson/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/3/2006 Baltimore, Md. Bayview Crematory 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee 29a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition maltor mation Physician days resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician; The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 🗖 📉 0 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 Impatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this Medical Certification: 27. Manner of Death 28a. Dale of Injury (Month, Day Year) 28b. Time of Injury 28c. tnjury at Work? After 28d. Describe how injury occurred 1 Naturai 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗀 Suicide Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) ģ 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funeral C To the Hospitei 1 Certifying Physician: To the best of my knowledge docth occurred at the tank, date and place, and due to the educe(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

Wolfe St Bultimore 600 32. Registrar's Signature

death (Item 23a) (Type, Print)

ORIGINAL

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		•	For State Registrar			•	•	rtificat					Reg. N	4000	- Comp	UDI	UU
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	/Medic	al	SARIAN MA	RIAN		vies			- 1-1	1	f D = ash	6	16	. County of Dea		1:48	5 M
	Examin	CI	4a. Facility Name (If not institution				lass		tim	Location) Death		1	Baltimore	iun		
	Funeral		UNIVERSITY OF MA	6. Sex	7.	Age (In yrs.	last birthday)			If Under Hours	24 Hrs. Min.	8. Date of B	irth	9. Bit	thplace	(State or	Foreign
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	land ow if		Usual Residence of Decedent 10a. State 10b. Count	у		10c. Cit	ty, Town or Lo	ocation					-		10d. J	Inside City	/ Limits
	Mary a-f sh	tor	Maryland Montgo	mery		Sil	ver Spri	ng								1 □XXes 2	2 🗌 No
	ith the	Director	10e. Street and Number					10f. Zip						itizen of What C	ountry?		
	s 23a	rail	11522 Lockwood Dr		Man Doord	ant Ever in II	20904							Africa 14. Race - Am	erican li	ndian	
	fter de	Funeral	11. Marital Status 1 □ Never Married 2 🛣 Ma	Marital Status 12. Was Decedent Armed Forces 1 □ Never Married 2 Married 1 □ Yes 2 □			If Yes, specify Cuban,				i, Puerto	Rican, etc.)		Black, White, etc.			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "natural", or Itams 23a or 28a-f show importent: If item 27 is marked other then "natural", or Itams 23a or 28a-f show principly or other traumatic event, I'm Machell Exert for must be notified at anone.	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:				1 ☐ Yes 2 ဩ No Specify:						Specify: B1			аск	
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ylar	should be nd Mental marked c	To E	Edward Davies				,			Eli	za Wi	lliams					
Jar	2 sho and Isma		19a. Informant's Name/Relation	,	Print)									or Town, State,		de)	
	1 and Health em 27		Prince Poneys/Husl 20a. Method of Disposition	and		20b. F	Place of Dispe	osition (Na)	ne of	= !		er Sprin Date	-	ryland 2 _ocation - City o		State	
TOL	ages ent of ht: If it		1 🛣 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	3 ∐Rem Specify)	oval from St	ate	cemetery, cre nion Cen		other plac	- 1	6/24/	2006	Burt	onsville,	Mary	vland	
Baltimore,	permit, Pages Department of I Importent: If ite any injury or of		21. Signature of Fundal Service		//	,	2	2. Name ar		ss of Facili							
<u> </u>	88 5 8		1 Noun	E M	elle.		76	01 Sar	dy Sp	ring F				nd 20707			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death														
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4	be executed ician and burial-transit	Examiner	resulting in death) Last Due to or as a consequence of):							fer	u da	75					
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Вох	The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c.		ome of pregn th 2 Feta		⊒Éctopic p	regnancy				Ī	23d. Date of de			
о. В	e deat	sicia	in the past 12 months? 1 XYes 2 □ No 9 □ Unknown			nt at time of o		Other (s						Month	Day	, 11	ear
<u>α</u>	that the		Part II. Other significant condi	tions contrib	outing to dea	ith but not res	sulting in the i	underlying o	cause giv	en in Part I		23e. Did	tobacco	use contribute	to the ca	ause of de	ath?
Records,	quires n sign ald be	d by										1 🗆	Yes :	2 ⊠ No 3□F	robably	/ 4 <u>□</u> Ur	nknown
000	e law requir has been si je 2 should l	Completed										24a. Wa	s an	24b. Were a	utopsy	findings a	variable use of
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of	Phys this ral di	To :	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?													
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Division	or Attence after death Diractor: I in by the	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	mined						28f. Location (Street and Number or Rural Route Number, City or Town, State)					er,		
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	•		DESSISLAVA	V. 8	BONEVA	MD			# 15	806				6/16/	06		
	10		30. Name and address of person	n who comp	eleted cause	of death (Ite			P-1.		M=	10 Lac I	201				
	Str	ate	Dessislava V. Bo 31. Date filed (Month, Day, Yes		32 80	aistrar's Sian	ature			imore	mary	/land 21	ZU I				
	Regist		JUN 3 0 2006 Registra & April														

			1 - For Amend Items	State of Marylan 25,27,28a-f p	d/Depa er MF @/	artment of Ho	ealth and N % & M Thb		iene g. No.	20606		
		e Pe	Decedent's Name (First, Middle, Last,)	2. Date of Deat Month	3. Time of Death						
	Physici /Medic		Omer Haywood Dinsm	ore	4-4-2	7:30 A ^M						
	Examin	er	4a. Facility Name (If not institution, give	· ·	4b. City, Town, or			4c. County of De	ath			
			Marvic Assisted Li 5. Social Security Number 6. Sec	<u> </u>	1	Pasadena If Under 1 Year	If Under 24 Hrs.	T	Anne A:			
	Funeral Director			IM 2DF	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 6-1-19	Year) 9. B	irthplace (State or Foreign Country)		
1	22 - 43		Usual Residence of Decedent	95				0-1-19	10	JA		
	yland Jow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits		
:	a-f.st	ctor	MD Anne Ar	unde1	Glen B	urnie				1 ☐ Yes 2X No		
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What 0	Country?		
w Cte	death with the Maryland me 23a or 28a-f show Linest to colifical at		616 Newfield Ro			21061			U.S.A.			
	teme	Funeral		12. Was Decedent Ever in U Armed Forces?	.S. 13. \	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh			
30	o 72 hours after death with the Marylan "natural", or Iteme 23e or 28e-f show salical Exercit caral Leccollists at	by F	1 ☐ Never Married 2 ☐ Married 3 € Widowed 4 ☐ Divorced	12⊈Yes 2 ☐ No If Yes, Give Year or Dates:		∏Yes 2. No	Specify:		Specify: V	vhite		
9500-51212	tural		15. Decedent's Edu		16a, Deced	lent's Usual Occupa	tion		16b. Kind of Busines	s/Industry		
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7 7	d within 7 giene. rr than "n	E O	4	College (1-401 5+)	U	.S. Army			Gove	nment		
פ	be filed tal Hygid d other event, I	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	Maiden Sumame)			
yland		10	Charles W. Dinsmo	re			Mary 1	Palistin	e Redwine			
Mar	s 1 and 2 should f Health and Mer llem 27 le marke othar traumailc	ili ş	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailin	g Address (Street a	nd Number or Rui	al Route Number	, City or Town, State,	Zip Code)		
	and tealth m 27		Mrs. Janice McFayd						ie, MD 210			
0	ges 1 ar t of Hea if Item or otha		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F	^	emetery, cren	sition (Name of natory or other place		Date	20c. Location - City of	r Town, State		
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e n	permit. Pages 1 Department of H Important: If Ite any Injury or ot		21. Signatur to un tral Service Licens	96					Funeral Ho			
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			shick, or heart failure. List only or	ne cause on each line.		, -		, ,	,	Interval Between Onset and Death		
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× o n	death certifi e attending id for use as	ician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3	Ectopic pregnancy	V		23d. Date of de Month	elivery Day Year		
	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of d	eath 5	Other (specify)			Monar	Day rear		
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5	ital o	Cer			Marvicionassisted Living, 205 Catalfa Ave., Pasadena, MD							
	To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the funer	edicai	(Check only 2 Medical Exami:	sician: To the best of my kno ner: On the basis of examina	wledge, death tion and/or inv	occurred at the time estigation, in my opi	e, date and place.	and due to the ca	use(s) and manner a	s stated		
	To the h within 24 To the F	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License						
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	Registr		APR 0 6 2006	Blower S.	1000							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JUNE FRANCESCA DANIELI 2006 9835 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 01/13/1954 Birthplace (State or Foreign Country)
 M.D. 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2√F MD Director 228-68-9023 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Modical Examinar must be notified at MD BALTIMORE BROOKLANDVILLE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1116 GREENSPRING VALLEY ROAD 21022 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Never Married 2 ☐ Married Itimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) ARTIST ART 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be COSTAGLIOLA FRANCESCO AGNES ROSS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s Department of Health ar Important: If Item 27 le eny injury or other trau once. 1116 GREENSPRING VALLEY RD.-BROOKLANDVILLE, MD 21022 GARY GENSLER / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CONG. 06/29/2006 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Switon 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Leverson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) CANCER Physician reasl rear /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Qualto (or as a consequence of) been signed by the ettending physicien and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) 「アイかことろ仕な」リなった。 Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 ₹No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an s certificete has t lirector, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral! 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 125205 June 29,2006 who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto. ml 21204 Bin(6701 31. Date filed (Month, Day, Year)
JUN 3 0 2006 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month RAYMOND ANGELO EMBRO 10:18PM 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville 3916 Tila Road If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 17, 1939 9. Birthplace (State or Foreign **Funeral** Days Hours 1**X** M 2□ F 214-46-8383 67 Canada Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at Baltimore Parkville 1 Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 21234 3916 Tila Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2**∑ X**o ģ Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. National Hock League Elementary/Secondary (0-12) College (1-4or 5+) Hockey Head Trainer 12 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event ADRS. 18. Mother's Name (First, Middle, Maiden Surname) Alice Couling Carl Embro. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3916 Tila Road-Parkville, Maryland 21234 ^{19a,} Informant's Name/Relationship *(Type, Print)* Shirley Embro-Spouse 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenmount Cemetery 6-30-06 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Chapel Of Memories 8800 Harford Road-Parkville, MD 21234 andrae LY1= Jadden 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pancientic **Physician** cana month) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ormed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -0 m June 27, 2006 - MID D40850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Dr. Britimar MD 21237 9103 VONNE OTTAVIAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 3 0 2006 Registrar

DHMH 17 Rev 1/2001

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Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? [] [] [Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** CHARLES WILLIAM ELLISON, JR. 29, JUNE 2006 11:15 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL CARROLL HOSPITAL CENTER WESTMINSTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 12☐M 2☐F Director 214-34-4886 Yrs. 5/28/1937 TENNESSEE Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or then "natural, or items 23s or 28s-f show the Medical Exeminer must be notified at Directo CARROLL WESTMINSTER 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 1760 GABLEHAMMER RD. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE þ Specify: 3 ☐ Widowed 4 ☐ Divorced 1966 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) HEATING & AIR Elementary/Secondary (0-12) College (1-4or 5+) MANAGER CONDITIONING 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental HATTIE CHARLES WILLIAM ELLISON, SR. CABLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health MARIANNE H. ELLISON -WIFE 1760 GABLEHAMMER RD., WESTMINSTER, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of F Important: if its eny injury or ot once. 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State EVERGREEN MEM.GARDENS 7/3/06 FINKSBURG, MD (4 ☐Donation 5 ☐ Other (8pecify) 21. signal r - Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENTEROCOCCUS SEDSU 00 Physician 10days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Section tidly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death P.O. F been signed by the should be detached 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by HAT LUZE. BRAINSTEM SCROKE, 3 Probably 4 Unknown SHOCK, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an mellilu icusetos 1 ☐ Yes 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No teral Director; A filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after d
To the Funeral Direct completely filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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D31660

291 STOWER AVENUE

061292006

Westminster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene and

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	/Medic		Lula Belle Edwards					JUNE	26	2000	
	Examin	er	4a. Facility Name (If not institution sive :	RIVERSID.	Ē	4b. City, Town, or	MAND			County of Death	
	Funeral Director		236-26-0936	7. Age (In yrs. 91	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	v. Year)	9. Birth Con Viro	nplace (Stete or Foreign untry) Jinia
	and w		Usuel Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
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20	s 1 and 2 should be filled within 72 hours after death with the Marylan f Healith and Mental hygiens. If Healith and Mental hygiens "natural" or Items 23a or 28a-1 show them 21a marked other then "natural" or Items 21a or 28a-1 show other treumatic event, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	f Yes, specify Cubai I □ Yes 2 ² No	n, Mexican, Puer Specify:	to Rican, etc.)		Black, White Specify: Whi	•
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Mar	2 she and is my		19a. Informant's Name/Relationship (Ty			g Address (Street a					
≥ Co	1 and 2 Health tem 27 other tr		Jackie D. Mosmille		2046	Knotty Pi	ine Dr.,	Abingdo			
5	ges 1 ar t of Hea If Item or other		20a. Method of Disposition 1 ☐ Syrial 2 ☐ Cremation 3 ☐ R	emoval from State	emetery, cren	sition (Name of natory or other place		Date	20c. Loc	ation - City or T	Town, State
aitimoi	permit. Pages 1 Department of P Importent: If Ite any injury or ot once.		'4 □ ponation 5 □ Other (Specify)	Bel	Air M	emorial C	dns 06-2	29-06	Bel 7	Air, Man	ryland
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			rsnock, or neart tailure. List only or	e cause on each line.	i j	or the mode or dying	g, soch as cardia	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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<u> </u>	death e atte	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnancy Other (specify)				Month	Day Year
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2	eath. or: A	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				res 2□No				
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	Registr		JUN 3 0 2	008 Maguer	15 h	Joan					-

Amend Item 21 State of Maryland / Department of Health and Mental Hygiene 2 per FH, G856, 06/30 Continuous of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Sallie G. Foster June 10, 2006 5:15 p.m. /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Oeath 4c. County of Oeeth Examiner 4903 Pilgrim Road Baltimore
If Under 24 Hrs. 8. C If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Oate of Birth (Month, Dey, Year) Min. **Funeral** Days 1□ M **3** F Months Hours 95 Director 05/06/1911 21**4**-22-3598 SC Usuel Residence of Decedent Pagas 1 and 2 should be filed within 72 hours after death with the Meryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f eh Y☐ Yes 2☐ No Director MD **Baltimore** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? frems 23a or 4903 Pilgrim Road 21214 Funeral 12. Was Oecedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Saltimore, Maryland 21215-0020 ò Specify: Black If Yes, Give Year or Oates: 1 ☐ Yes 2 XNo Specify: þ 3 XWidowed 4 ☐ Oivorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) South Carolina School 12th grade 2 years Teacher System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maid Be Department of Health and Mental Important: if item 27 is marked o James Grays 2 Lula Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Dorothy M. Glover/Daughter 4903 Pilgrim Road, Baltimore, MD 21214 20b. Plece of Disposition (Name of cemetery, crematory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Red Hill Church Cemetery 06/17/06 Blackstock, SC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Services 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Advanced Dementia Examiner Due to (or as a consequence of): Physician/Medical Examiner Advanced Age usa as tha bunal-transit Attending Physician: The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Oue to (or as e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ba datached 1 Yes 2 No 3 Probably 4 Unknown Dehydration Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? paga 2 should TLI Yes 20 No 1 ☐ Yes 2 ☐ No cartificata 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home Testidence 6 Other (Specify) Medical Certification: To 3□ DOA 1 ☐ Yes 2 No this 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigetion 1 Netural
2 Accident 1 ☐ Yes 2 ☐ No daath. Director: A 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ò To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and manner as stated.

The physician is a stated of the cause of the 29a. Certifie (Check onh al Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature title of c tifier D0056934 10 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Gene E. Green, M.D., 1000 East Eager St., Baltimore, MD 21202 32. Registrar's Signature State Registrar 23466

			For State Registrar	State of	of Maryla	•	artment of		Sec.	/lental Hy	giene Reg. No	006	206	12
	,	62	Decedent's Name (First, Middle	e, Last)						2. Date of De			3. Time o	Death
	Physici /Medio		Nellie Lilli							June 21	-		4:45	РМ
	Examir	er	4a. Facility Name (If not institution Manor Care, Woo	-			4b. City, Town	i, or Locatio nsvil			4c. 0	County of Death Baltim		
	Funeral		5. Social Security Number 214–24–8470	6. Sex 1 ☐ M 2 🛱 F		s. last birthday) Yrs.	If Under 1 Ye Months Day		er 24 Hrs. Min.	8. Date of Big (Month, Da	ay, Year)	Cor	nplace (State	or Foreign
100	Director		Usual Residence of Decedent		76					Aug. 2	, 192	9 Mar	ryLand	
	arylar show	<u>.</u>	10a. State 10b. County			City, Town or Lo							10d. Inside C	
	8a-f	Director	Maryland n/a	3	Ва	ltimore								2 No
	3a or 2	ai Dir	10e. Street and Number 517 Sunset Road	Ē			10f. Zip Cod				10g. Citiz	en of What Col	untry?	
	deatl	Funeral	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Decedent of If Yes, specify C	f Hispanic (Origin? (Sp	ecify Yes or No	0- 1	4. Race - Amer		
36	d within 72 hours after death with the Maryland Jene. r than "natural", or Itams 23a or 28a-f show Ita Madical Exendrat cust be notified at	by Fu	1 ☐ Never Married 2 ☐ Marri 3 ※ Widowed 4 ☐ Divorced	ied 1 ⊟Yes If Yes Gi	2 XNo		1 ☐ Yes 2 💢 N			nican, etc.)		Black, White Specify: W	hite	
Ö	2 hou	ted		t's Education			dent's Usual Oc			-!	16b. Kin	d of Business/I	ndustry	
21215-0036	within 7 ene. than "n	Completed	Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life.	kind of work do DO NOT use ret Keeper	ne auring m ired)	ost of work	ang	Fr	ood Ser	vri co	
d 2	H S T	ပိ	17. Father's Name (First, Middle,	<u> </u>		DOOK	recher	18. Mo	ther's Nam	e (First, Middle	<u> </u>		VICE	
Maryland	2 to 2 to 2	To B	Anton Shimuk					Ver	onica	Asadow	vska			
lar,	and and is m		19a. Informant's Name/Relations				ng Address (Stre				-		ip Code)	
	s 1 and 2 f Health itsm 27 other tra		Lynda J. Henry 20a. Method of Disposition	/ Daugnte		_	rest Av	enue,		Date		ation - City or 1	Town State	
nor	Pages nent of It ant: If its ary or of		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	cemetery, crei	matory or other p			/2006		•		
Baltimore,	=====		21. Signature if Funeral Service		· A		edral Ce 2. Name and Ad			ubbardF		imore, alHome.		Land
m	Depart Impo		Krishan	2 Om	L	4	1107 Wil	kens						1229
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea	ath. Do not ent	er the mode of o	tying, such	as cardiac	or respiratory a	rrest,		Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition resulting in death)			RDIAL	INF	ARC	Tio	m			Onset and	
	/Medical Examiner		resulting in dealth)	Due to	or as a conse	ENZID	d						4	,
	\$ ₁	ler	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conse								0	
10	cuted nd iransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	С										
8760,	cate be executed physician and the burial-transit	i Ex	resulting in death) Last	Due to	(or as a conse	equence of):								
387		edicai		d										
Box (death certifii e attending p id for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou			7				23	3d. Date of deliv	very	
.O.	0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		birth 2□Fe nant at time of lown		Ectopic pregna Other (specify)					Month	Day	Year
<u> </u>	\$ \$ \$ \$ \$		Part II. Other significant condition	ons contributing to d	eath but not re	sulting in the u	nderlying cause	given in Pai	t I.	23e. Did 1	tobacco us	e contribute to	the cause of o	death?
Vital Records,	quires in sign uld be	ed by	CEREBRO VASC	WLAR A	eci dem	Tim T	RIGHT	HEN	liPle!	in 10	Yes 2 🖪	No 3□ Pro	bably 4 🗆	Unknown
ဝ၁	e taw requir has been si je 2 should l	Completed	HYPERLIPE	DEMIA					•	24a. Was		24b. Were aut	opsy findings	available
ž		Com	,								ormed?	death?	2 No	2059 01
/ita	Physician: this certific ral director,	Be	25. Was case referred to medica examiner?				1	24	_	h Check only				
of	> 0 0	: To	1 ☐ Yes 2 V No 27. Manner of Death	Hospital: 1 🗆		☐ ER/Outpatier 28b. Time o	II JUDOA		Nursing Ho	ome 5 Resi			ify)	
on	ding h. After fune	tion	1 Natural 5 Pendir 2 Accident investi	g (Mon	th, Day Year)	Injury	٧	Vork? ☐ Yes 2	□No	Zou. Describe	now injury	occaried		
Division	or Attending after death. Dirsctor: Afte In by the fune	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be 28e. Place	of Injury · At ing, etc. (Spec	home, farm, str	eet, factory, offic	Э		28f. Location (Street and wn, State)	Number or Rui	ral Route Num	nber,
ā	itel or A rs after rei Dirs led in by	Cert	4 Tromode	Dullo	iiig, etc. (3pec	y/				City of 10	wii, Siale)			
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edicai	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the Examiner: On the b and man	e best of my kr pasis of examinated.	nowledge, deat nation and/or in	h occurred at the vestigation, in m	time, date y opinion, d	and place, eath occur	and due to the red at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s	;)
	To the within 2 To the complet	Me	29b. Signature and title of certifie		1.			nse numbe			29d. Date	signed (Month	, Day, Year)	
	22		► N. 5-	Kellen	0		D.	304	-69		Jur	2	3, 200	26
	10	l	30. Name and address of person	who completed cau	se of death (Ite	эт 23а) (Туре,	8850, C	ndakumar olumbia 100 bia, MD	Parkway,	# 308			V 200000 0	
ji .	Sta	ite	31. Date filed (Month, Day, Year)	732. F	Registrar's Sign	nature	The state of the s	410-77	2-798	4				
*	Regist	rar	JUN 3 0 20	106	and Sign	A TOP OF THE PARTY								

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryl		artmen <i>rtificati</i>			nd Mental Hy	giene Reg. No.2	06	20613
	Physici /Medi		1. Decedent's Name (First, Middle, L Ethel Ellen Gi	,					2. Date of De Month	Day Q3	Year	3. Time of Death Q 1.59 Au
	Examir Funeral			Tene(0) H(0) Sex 7. Age (In)	vrs. last birthday)	4b. City, If Under Months	Sal	If Under 24	Death Hrs. 8. Date of Bill Min. (Month, Da	ay, Year)	of Death	ce (State or Foreign
	Director		215-22-4958 Usual Residence of Decedent 10a. State 10b. County	63	Yrs. City, Town or Lo	ocation			Nov 5,	1922	Maryla	
	or 28a-f si	Director	MD 10e. Street and Number	"	Balti	more 10f. Zip	Code			10g. Citizen of	What Country	1 √Yes 2 No
36	within 72 nouts atter death with the maryland ene. Then "natural", or liems 23e or 28e-f show the Modical Examinat must be notified at	by Funeral (1100 Bolton St ₁ 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☒ No if Yes, Give Year or Dates:	1	Was Deced		212 spanic Origin n, Mexican, F Specify:	01 1? (Specify Yes or No Puerto Rican, etc.)	US 14. Rac Blac Specifi	ce - American ck, White, etc	
Maryland 21215-0036	within 72 hour iene. Than "natural the Wedical El	Completed t	15. Decedent's (Specify only highest g	ducation	(Give	DO NOT us	k done di	urina most o	f working	16b. Kind of B	usiness/!ndus	
/land 2	Mental Hygi Mental Hygi Irked other	To Be Co	17. Father's Name (First, Middle, Las Leander Mooney		nouse	wile			Name (First, Middle			
Baltimore, Mar	perint. Fages I and 2 should be filed within 72 hours after death with the marylan bepartment of Health and Mentall Hygiene. Important: If filem 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ODGs.		19a. Informant's Name/Relationship Richard Gibson/ 20a. Method of Disposition 1 Burial 2 Cremation 3	SON 201		Plea	sant	Valle	or Rural Route Numb ey Drive C Date		11e, M	D 21228
Baltir	Departme Importan any injur.		4 Donation 5 Other (Special Signature of Euneral Service Lice	//	or St	Name and ate A	nato	my Boa	ard 655 W. 201	Baltimo	ore St	reet
1	hysician and busician and the prival-transit	al Examiner	23a. Pan1. Enter the disease for corshook, or heart failure. List on! Immediate Sause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	sequence of):		of dying	, such as ca	rdiac or respiratory a	rrest,	In	oproximate terval Belween nset and Death
Box 6	e ettending of for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3 [Ectopic pre				23d. Dat	e of delivery nth Da	y Year
	been signed be should be dete		Part II. Other significant conditions	contributing to death but not	resulting in the ur	nderlying ca	use giver	in Part I.		obacco use contr res 2 \(\text{No} \)		
al Reco		Completed							24a. Was autop perfor 1 Yes	rmed? d	Were autopsy prior to complete the complete	findings available etion of cause of
Division of Vital Records,	after death. I Director: After this certificate has d in by the funeral director, page 2	tlon: To Be	25. Was case referred to medical examiner? 1 Yes	28a. Date of Injury (Month, Day Year,	ER/Outpatien 28b. Time of Injury		Other Ic. Injury a Work?	4 ☐ Nursir	Death (Check only only only only only only only only			
Divis	ours after death erel Director: A filled in by the f	Certification:	3 Suicide 6 Could not learnined		t home, farm, streecify)	eet, factory,	office		28f. Location (5 City or Tow	Street and Numbern, State)	er or Rural Ro	oute Number,
H edi	within 24 hours after To the Funerel Directory completely filled in by	ledical	one)	nysician: To the best of my k miner: On the basis of exam and manner stated.	rnowledge, death ination and/or inv	estigation,	in my opir	nion, death c	occurred at the time, o	date and place, a	and due to the	cause(s)
)	3 2 5			7 0		E	License i	5 Q	9	29d. Date signed	a (Month, Day) a 3-0 aeral	
	Sta Registra	te	31. Date filed (Month, Day, Year)	Registrar's Sig	ladh	avar	J. C	100	Marylan	d Gen	eral	Hospital

DHMH 17 Rev 1/2001

			1 - State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artmen tificate	t of H	ealth a	and M	ental Hygi	ene 2	006	20	614
	Physici	an	1. Decedent's Name (First, Middle, Last)								2. Date of Death Month 06 1	Day	2006°	3. Time of	
	/Medic	al	Stephen Gaver	tract and au	horl		Ab City	Tour or	Lagation		06 1		2006 hty of Death	12:04	а м ———
	Examin	ier	4a. Facility Name (If not institution, give s 8618 Mapleville Ro		ber)				Location o sboro				ingto		
	Funeral		5. Social Security Number 6. Sex	7	. Age (In yrs.	last birthday)	If Under	1 Year	If Under 2		8. Date of Birth (Month, Day,		9. Birth	place (State o	r Foreign
	Director		215 - 42-3185	M 2□F	62	Yrs.	Months	Days	Hours	Min.	June 9,	1944		vland	
	p s		Usual Residence of Decedent 10a. State 10b. County	-	10c. C	ity, Town or Lo	cation							10d. Inside Ci	ty Limits
	daryli f aho	ō	MD Washingto	on		Boonsb								1 🗆 Yes	
	r 28a-	rect	10e. Street and Number				10f. Zip	Code			10	g. Citizen o	of What Cor		21
	h with	aj D	8618 Mapleville Ro	ad					21713	3		US.	A		
	ems ser mi	Funeral Director		2. Was Deced	lent Ever in U	J.S. 13. V	Was Deced	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14. R		ican Indian,	
2	s afte	by Fu	1 ☐ Never Married 2 ☑ Marned 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Da	2 🔼 No		1 □ Yes 2		Specify:				city: wh	_	
3	thour		15. Decedent's Educ		.05.	16a. Deced	dent's Usua	l Occupa	tion		10	6b. Kind of	Business/I	ndustry	unk
2	hin 72	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-	4or 5+)	(Give	kind of wor DO NOT us	k done d e retired)	uring most	of working	ng			•	dine
V	ed wit	Completed	12	0		woo	dwork								
yland	be fill Hy of oth	Be	17. Father's Name (First, Middle, Last)								(First, Middle, Ma		ame)		
2	hould d Mer marke matic	ဥ	John Emory Gaver 19a, Informant's Name/Relationship (Type	e Print)		19h Mailin	ng Address	(Street a			Evanne I		m State 7	in Code)	
Z	nd 2 s lith an 27 is r		Ora T. Gaver/spo			1					Boonsbor		217	_	
nore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f ahow amy injury or other traumatic event, the Medical Examination must be notified at ODGe.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☑ Donation 5 ☐ Other (Specify)	moval from S		Place of Dispo cemetery, cren	sition (Nam natory or o	ne of ther place)	Da	ate 20	Oc. Location	n - City or 1	Town, State	
Dailtimor	permit. P Departme Importar any injur		21. Signature of Fun ral Survices conse	ade, b	pecto				-		655 W. I	Balti	nore :	Street	
8	Physician /Medical Examiner		23a. Part1. Enter the disease, or comples shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	ACVT	ch line. E LY/ r as a conse	th. Do not enter MPHB1 quence of):		of dying	, such as	cardiac or	r respiratory arres	it.		Approximate Interval Bets Onset and I	ween Death
,00/8/	certificate be executed nding physician and use as the buriat-transit	dical Examiner	rr any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last		r as a consec										
O. Box o	death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		th 2 ☐ Fetant at time of	al death 3 □	Ectopic pro					1	Date of delin		'ear
cords, r	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions con-	ributing to dea	ath but not re	sulting in the ur	nderlying ca	luse give	n in Part I.		23e. Did toba 1 ☐ Yes			the cause of debably 4 🔲	
Meco	The law require ate has been si page 2 should b	ompieted			<u>_</u>						24a. Was an autopsy performe	gl?	D. Were aut prior to co death? 1 \(\sum \text{Yes}	opsy findings a	available ause of
VII a		Be C	25. Was case referred to medical						26. Place	of Death	(Check only one)	_ No	1 1 163	20 140	
0	Physician: this certific ral director,	To	examiner? 1 ☐ Yes 2 📉 No	ospital: 1 □ In	patient 2	ER/Outpatien			4 🗀 1901	rsing Hom	ne 5 Anesiden	ce 6 □C	ther (Spec	ify)	
Sion o	ng fter mer	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month	Injury , <i>Day Year)</i>	28b. Time of Injury	M 21	Bc. injury Work 1 🗆 Y	at ? es 2 □ N		8d. Describe how	injury occ	urred		
DIVIS	s after de s Diracto ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place o buildin	of Injury - At h g, etc. (Speci	iome, farm, stre fy)	eet, factory	, office		2	8f. Location (Stre City or Town,		nber or Rui	ral Route Numi	ber,
	To tha Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edicai	29a. Certifier Check only one) Check only one) Check only one)	er: On the ba: and mann	sis of examina or stated.	ation and/or inv	estigation,	in my op	inion, deat	н оссигге	d at the time, dat	and place	and due	to the cause(s))
	To t To t	₹	29b. Signature and title of certifier	mor	us		290	D34	761	•	Estate	1. Date sign	ned (Month) 2/ŏ6	. Day, Year)	
			30. Name and oddress of person who con BMAN M. O CONA	npleted cause	of death (Ite	m 23a) (Type.	Print)	57	-, 1	(RED)	efide	MP	217	701	
	Sta Registr		31. Date filed (Month, Day, Year)	6 32.76	gistrar's Sign	ature	astal .		/					-	

			1 - For State Registrar		State of	Marylar	nd / Depa	artmen <i>rtificat</i>	nt of H	lealth a Death	and M		giene	2006	200	515
	, to	ba e	1. Decedent's Nam	e (First, Middle	, Last)							2. Date of De	ath		3. Time o	of Death
T _a	Physici /Medi		PATRICIA		GIRONDO						ļ	Month IUNE 2	Day 5	2006 Year	8:30	рМ
	Examir		4a. Facility Name (I	f not institution	give street and num	ber)		4b. City,	Town, or	Location o	of Death		4c.	County of Dea	th	
		蜀	15034 CHERR						JREL				F	PRINCE GE	ORGES	
	Funeral		5. Social Security N		6. Sex 7 1 ☐ M 2 X ☐ F		. last birthday) Yrs.	If Under Months		If Under :	24 Hrs. Min.	8. Date of Bir (Month, Da	th <i>y, Year)</i>	9. Bir	thplace (State ountry)	or Foreign
	Director		177-54-9075 Usual Residence of		,,	45	115.					MAY 23,	1961	PENN	SYLVANNI	Α
	yland		10a. State	10b. County		10c. Ci	ity, Town or Lo	cation							10d. Inside C	City Limits
	Mar	tor	MARYLAND	PRINCE	GEORGES	LAUF	REL								1 🔯 Yes	2 □ No
	or 28	jre	10e. Street and Nur	mber				10f. Zip	Code				10g. Cit	izen of What Co	ountry?	
	23a	Funeral Director	15034 CHERR	YWOOD DR	IVE			LA	JREL				PRIM	NCE GEORG	ES	
	tems fems	- Pu	11. Marital Status		12. Was Deced Armed Ford	ent Ever in U	J.S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Ame Black, Whit		
36	should be filed within 72 hours after death with the Maryland Menial Hyglene. marked other than "natural", or items 23a or 28a-f ehow marked other than "natural", or items 23a or 28a-f ehow marked other than "natural Earnelliad at interest.	by Fu	1 Never Marri		If Yes, Give	*	1	1 🗆 Yes		Specify:	, , , , , , , , , , , , , , , , , , , ,			Specify: WHI		
21215-0036	hour	ed b	3 Widowed		Year or Dat	es:	16a Dana	danka Hawa	-1.0							
5	in 72	Completed			t grade completed)		16a. Deced	kind of wo DO NOT us	rk done a	lurina most	of workin	ig .	16b. Ki	nd of Business	/Industry	
212	with iene.	mo	Elementary/Seco	ndary (0-12)	College (1-4	lor 5+)				, NURSE				MEDICAL		
D	Hygid other	Be C	17. Father's Name	(First, Middle, L	ast)							(First, Middle,	Maiden			
<u>a</u>	lid be fental rked o	ToB	FRANK GIRON	DO						PATRI	ICIA B	OARDMAN				
Maryland	2 should and Men is marke sumatic	-	19a. Informant's Na	ame/Relationsh	ip (Type, Print)		19b. Mailin	ng Address	(Street a				r, City o	r Town, State, 2	Zip Code)	
	rtr		CATHERINE G	IRONDO/S	ISTER		15034 0	CHERRY	NOOD E	DRIVE	LAURE	L MARYL	AND	20707		
altimore,	0 0		20a. Method of Disp		3 □Removal from St		Place of Dispo	sition (Nan	ne of ther place	9)	Da	ate	20c. Lo	cation - City or	Town, State	
Ĕ	0 0		4 Donation			ale	TRO CREMA	-	·		/28/20	06	CATO	NSVILLE,	MARYLAND	
Ž	permit. Pag Department Important: i any injury o		21. Signature of	e Service L	icensee	,		. Name an		s of Facility	4					
<u>n</u>	205 20			Wan	E Wells			01 SAN	NDY SP	PRING R	ROAD	LAUREL M	ARYLA	ND 2070	7	
			23a. Part1. Enlef the shock, or hear	ne disease, or o rt failure. List o	complications that cause on each	ised the deat th line.	th. Do not ente	er the mode	e of dying	g, such as o	cardiac or	respiratory ar	rest,		Approximat Interval Bet	ween
	Physician		Immediate Cause (disease or condition		ENDOME:	TRIAL CA	ANCER								Onset and 6 MONTH	Death
	/Medical Examiner		resulting in death)	1		as a conseq	,									
		_	Sequentially list cor	nditions,	b		S FROM E	ENDOME	TRIAL	CANCER	?				1 MONTH	
	B H E	Examine	if any, leading to im cause. Enter Unde Cause (Disease or	riying iniury	Due 10 (0)	as a conseq	juence of):									
	be executed icien and burial-transit	xar	that initiated events resulting in death) L		c Due to (or	as a conseq	uence of):									
2/60	icate be executed physicien and stransit sthe burial-transit						,							İ		
	ificate g physi	Physician/Medical			d											
X Q Q	that the death certificed by the attending properties as	N/M	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outco								2	3d. Date of deli	verv	
מ	death e atte	icia	in the past 12 1 Yes 2	months?	4☐ Pregnar	n 2 ☐ Feta It at time of d		Ectopic pre Other (spe						Month		Year
j.	at the by th tache	hys	9 🗆 Unknown		9□ Unknow											
Ś	8 5 6	by F			s contributing to deal	h but not res	ulting in the un	iderlying ca	ause givei	n in Part I.		23e. Did to	bacco u	se contribute to	the cause of d	leath?
ם מ	w requir been si should l	ted	TYPE	2 DIABE	IES			_				1 🖄 Y	es 2[No 3□Pro	obably 4 🗆 t	Jnknown
ည စ	as as b	Completed										24a. Was a		24b. Were au	topsy findings	available
_ '	t see	Con										autop: perfor	med?	death?	completion of c	ause or
VITAI	ysician: Th is certificete director, pag	Be	25. Was case referr examiner?	ed to medical						26. Place o	of Death	Check only or	_			
5	© 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.	၉	1 Yes 2 X		Hospital: 1 🗆 Inp		ER/Outpatient			4 LI NUIS	sing Home	e 5≹ Resid	ence 6	Other (Spec	cify)	
	Jing Phys J. After this funeral di	Ö	27. Manner of Death 1 X Natural	5 Pending		njury Da <i>y Year)</i>	28b. Time of Injury		Bc. Injury Work			d. Describe h	ow injury	occurred		
Sion	Attending r death. ector: Afte by the fune	icat	2 Accident 3 Suicide	investiga 6 Could no	ot be	Laborate Asia		М		es 2 N						
<u> </u>	or A efter Direction by	Certification:	4 Homicide	determin	led 286. Place of building	etc. (Specify	ome, farm, stre y)	et, factory,	, office		28	If Location (S: City or Town	treet and n, State)	Number or Ru	ral Route Num	ber,
-	ours ours filled		29a. Certifier	1 Certifying	Physician: To the be	est of my kno	winden doeth		a the time	n det d						
	24 h 24 h Fur etely	edicai	(Check only one)	2 Medical E	xaminer: On the basi and manner	s of examina	tion and/or inv	estigation,	in my opi	nion, death	piace, an occurred	id due to the c I at the time, d	ause(s) a ate and	and manner as place, and due	stated. to the cause(s))
	To the Hospital or Attending Phywithin 24 hours etter death. To the Funeral Director: After the completely filled in by the funeral	Me	29b. Signature and	title of certifier	<u> </u>			29c.	License	number		2	9d. Date	signed (Month	, Day, Year)	
1			MAN	& MA			\bigcirc	04	3237					27, 2006	,	
	6	ŀ	30. Name and addre	iss of person w	ho completed cause of	of death (Item	1 23a) (Type, F						OINE	21, 2000	<u> </u>	
	ر.		PAUL ARMSTR				ARK DRIV		TE 10	2 LAU	REL. N	MD 20707				
	Sta	100	31. Date filed (Monti	h, Day, Year)	32. Aeg	istra r 's Signa	ture	cath)								
	Registr	ali .		IIN 3 0	2006	1000 A	1 1 1 1 1									

			1 - For State Registrar		nd / Depa	artment of Health a rtificate of Death	nd Mental Hy	•
	Physic /Medi	cal	Decedent's Name (First, Middle, Last STANLEY		GOL	DBERG	2. Date of Dea Month JUNE	26 2006 7:13 A M
1 OF 12	Exami Funeral Director	ner	4a. Facility Name (If not institution, give 11 SLADE AVENUE A 5. Social Security Number 6. Se 219-03-6352	PT. # 806	. last birthday) Yrs.	4b. City, Town, or Location of PIKESVILLE If Under 1 Year If Under 2 Months Days Hours		4c. County of Death BALTIMORE 9. Birthplace (State or Foreign Country) Country) MD
	D	tor	Usual Residence of Decedent 10a. State 10b. County MD BALTIMO	10c. C	ity, Town or Lo		12/02/	1921 MD 10d. Inside City Limits 1 □ Yes 2√ No
	eath with the	Funeral Director	10e. Street and Number 11 SLADE AVENUE A			10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.
9600	d within 72 hours after death with the Maryland yiene "natural", or Iteme 23a or 28a-1 ehow tre Medical Exaciliar meat be recitified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1V Yes 2 NARMY Vear or Dates:	'	Vas Decedent of Hispanic Origi i Yes, specify Cuban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	d within giene. rr then	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	- (Give life. L	ent's Usual Occupation kind of work done during most of OO NOT use retired)	of working	16b. Kind of Business/Industry PEPSI COLA
Maryland	m - 0 =	To Be	17. Father's Name (First, Middle, Last) WILLIAM 19a. Informant's Name/Relationship (Ty		OLDBERG	MINNI		Maiden Surname) BERNSTEIN r, City or Town, State, Zip Code)
Baltimore, Ma	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny Injury or other traumatic evones.		MARJORIE STRASBURG 20a. Method of Disposition 1 Disposition 1 Donation 5 Other (Specify) 21. Signature of Funeral Service License	ER/FRIEND semoval from State BAL	11 S Place of Disposemetery, crem TIMORE	LADE AVENUE AP sition (Name of latory or other place) HEBREW CONG Name and Address of Facility	T.#806-BALT Date D6/29/2006 SOL LEVINS	TIMORE, MD 21208 20c. Location - City or Town, State REISTERSTOWN, MD SON & BROS., INC.
2	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fill any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a consequence to for a consequence to for a co	The Do not enter the Do			PIKESVILLE, MD 21208 est. Approximate Interval Between Onset and Death Charles
.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Records, P.	e law requires that has been signed b ye 2 should be deta	Completed by Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	derlying cause given in Part I.	24a. Was an autops	V prior to completion of cause of
	hysician: Th this certificate al director, pag	To Be	1 163 22 00		ER/Outpatient	26. Place of 3 DOA Other: 4 Nursi	Death Check only on	No 1□Yes 2No
Division of Vital	I or Attending Physician: The I after death. Director: After this certificate ha in by the funeral director, page	Certification:	27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specify	28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No et, factory, office	28d. Describe ho	reet and Number or Rural Route Number
_	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	Medical Ce	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inve	occurred at the time, date and postigation, in my opinion, death of	lace, and due to the ca occurred at the time, da	tuse(s) and manner as stated. ate and place, and due to the cause(s)
	To To t	Σ	29b. Signature and vittle offcertifier 30. Name and addr person who or	MD MD)	D29373		3d. Date signed (Month, Day, Year) 6/26/06 5 MD 21093
	Sta		30. Name and addr person who or ERIC J. SELFLER 31. Date filed (Month, Day, Year)	32. Philistrar's Signa	FAUS	RD, SUITE 200 L	UTHERVILLE	MD 21093

DHMH 17 Rev 1/2001

			1 - For State Registrar	State	of Mary	land / Depa <i>Cei</i>	artment <i>rtificate</i>			and M		gien Reg. No	6 U	06	20	617
	Dhysisi	a m	1. Decedent's Name (First, Middle	, Last)							2. Date of Dea	ath		Year	3. Time	of Death
	Physici /Medio		Virginia Hurtt								May 23	, 2	006	Tear	8:30	РМ
1	Examir	ier	4a. Facility Name (If not institution		rumber)		4b. City, To			of Death		40	c. County o	f Death		
			3601 Clarks Lat 5. Social Security Number	1e #516 6. Sex	7 Ago //o	yrs. last birthday)	Ba. If Under 1	1tim	ore	24 Uze	0.0					
	Funeral Director		219-16-7232	1□M 2√2F		82 Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Day	h y, Year,)	Cou		or Foreign
			Usual Residence of Decedent			02					Feb 2,	192	.4	New	York	
	how		10a. State 10b. County		100	c. City, Town or Lo	cation							1	0d. Inside (City Limits
	a-fs	ç	MD			Baltin	nore								1X Yes	s 2 □ No
	if to 0.28	Director	10e. Street and Number				10f. Zip C	Code				10g. Ci	itizen of WI	nat Cour	ntry?	
	ath w	ral	3601 Clarks La						1215				US.	A		
	er de	Funeral	11. Marital Status	Armed F		in U.S. 13. \	Vas Deceder Yes, specifi	nt of His y Cuban	panic Orig	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		14. Race Black	- Americ	an Indian, etc.	
36	rs aft	by F	1 Never Married 2 Marr 3 Widowed 4 Divorced	led 1 ∐ Yes If Yes, C Year or			□Yes 2¶	No No	Specity:			Ì	Specify:			
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other then "naturel", or items 23s or 28s-f show ent, the Medical Evanifact must be incitified at	ed	15. Deceden	's Education		16a, Deced	lent's Usual (Occupat	tion			16b K	Cind of Bus	inoss/le	duntas	
212	n 72	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed	(1-4or 5+)	(Give	kind of work OO NOT use	done du retired)	iring most	of workin	g	IOD. N	VINU OI BUS	mess/m	dustry	
212	d with	E O	12	3	(1-40r 5+)	home	maker					,	own h	0m 0		
	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "naturel", or Items 23s or 28s-f show event, the Medical Examirat must be motified at	Be	17. Father's Name (First, Middle,					1	18. Mothe	r's Name	(First, Middle,					****
Maryland		ို	Wallace Aloy:	isius New	ton				The	resa	Marie N	Wood	dward			
a	d 2 should th and Mer 7 is marke treumatic	y 4	19a. Informant's Name/Relations		_				nd Numbe	r or Rural	Route Numbe	r, City o	or Town, S	tate, Zip	Code)	
	is 1 and of Health Item 27 other tr		Patricia McMon	ris/daug					a Ave	enue	Baltime	ore	, MD	212	06	
Baltimore,	permit. Pages 1 Depertment of H Important: if Ite any injury or ott	,	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (S)	pecify)	n State	Ob. Place of Dispos cemetery, cren	sition (Name natory or othe	of er place))	Da	ate	20c. L	ocation - C	ity or To	wn, State	
Balt	permit. Depertr Importa		21. Sign tur of Fuveral Service Ronald	Wide,	Direct	or St	Name and a ate Ar ltimor	nato	my Bo	, pard 21201	655 W.	Ba1	Ltimo	re S	treet	
Н			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the						respiratory arr	est,			Approxima	
	Physician	i	Immediate Cause (Final	only one cause on		LATED		AR	200	MV	OPATH	1			Onset and	Death
	/Medical		disease or condition resulting in death)	aDue to		nsequence of):		-/(1	1010	V () C		-			OY	RS-
	Examiner		Constitute for any other service			,										
-	n =	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to	o (or as a con	nsequence of):										
	nd ransi	Examiner	that initiated events	c												
Ž.	e exe	ĒX	resulting in death) Last	Due to	or as a con	nsequence of):										9
8/60	icate be executed physicien and s the burial-transit	dicai		d										_		
	entific ding p		IF FEMALE:				-					-				
ğ	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?		birth 2 IF	Fetal death 3	Ectopic pregi] :	23d. Date of		,	V
	the e	yslc	1 ☐ Yes 2 🕍 No 9 ☐ Unknown	4∐Preg 9□Unkr	nant at time	of death 5	Other (speci	ity)					MONIT	1	Day '	Year
ī.	that if	5	Part II. Other significant conditio	ns contributing to d	death but not	resulting in the up	derking caus	so awan	in Part I		23e. Did tot	2222	.00 .0000			1
ras,	To the Hospital or Attending Physicien: The law requires that the death certit within 24 hours atter death: within 24 hours atter death: To the Furnatal Director: After this certificete has been signed by the ettending completely filled in by the funeral director. page 2 should be detached for use as	ed by	•			- Todaking in the dif	derlying data	36 GIVEII	ni raiti.		1 \(\text{Y} \)				ecauseoro ubly 4 ⊟t	
ecor	aw re	Completed									24a. Was a	n	24b. We	re autop	sy findings	available
ř	The The ste ha	E									autops		dea	um?	sy findings pletion of c	ause of
7	ien: rtifice	Bec	25. Was case referred to medical					2	26. Place	of Death /	Check only on	el No	1	Yes	2LI NO	
>	nysic direc	2	examiner? 1 ☐ Yes 2 ☐No	Hospital:	Inpatient 2	2 ER/Outpatient	3□ DOA	Other:			5 🗷 Reside		6 ∏Other	(Specify		
0	ng Pl		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year	r) 28b. Time of Injury	28c.	. Injury a Work?			d. Describe ho					
SIOIS	endii eath. or: A he fu	at	2 Accident investig	ation		,,,	М		s 2□N	0						
Ĕ	ter d lirect n by t	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Plac	e of Injury - A ling, etc. (Sp.	At home, farm, stre	et, factory, of	office		28	f. Location (St. City or Town	reet and	d Number	or Rural	Route Num	ber,
ב	traic rat D rat D				51											
	Hosp 24 ho Fune stely fi	edical	29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the taxaminer: On the taxaminer	e best of my pasis of exam nner stated.	knowledge, death nination and/or inve	occurred at t estigation, in	the time, my opin	date and ion, death	place, an	d due to the ca at the lime, da	ause(s) ate and	and mann place, and	er as sta	ted. the cause(s)
	o the	Me	29b. Signature and title of certifier	and mar	iller stated.			icense n					e signed (A			
	- s - ō		1 2-	Min	MD				47	40					h 20	06
		+	30. Name and address of person v	no completed care	se of death (Itam 23a) /Tugo E	rint)				700	200		ال نار ا	1 20	- 0
			Echen Flesh	in H.	roter	Z Car (Type, P	Salt:	" (F	10:77 Vb		TRA MD	7	17.87	- 1	960	
	Stat	е	31. Date filed (Month, Day, Year)	32°F	Registrar's Si	ignature	AP D		, e		7	_	.006		100	
	Registra	ar	JUN 3 0 7	2006	Esper .	ignature	200									

		1	For State	State of Ma		/ Depa	artme		alth and			e 20	06	20618
Phys /Me Exan	dica	4	Registrar 1. Decedent's Name (First, Middle, Lass Helen Marg La. Facility Name (If not institution, give	aret Hin			4b. Cit		ocation of Deat	2. Date of Month	of Death	ay C. County	Year 006 of Death More	3. Time of Death
Funer Directo		2	6. Social Security Number 2.12-03-2182		e (In yrs. Ia	st birthday) Yrs.		er 1 Year	If Under 24 Hrs Hours Min.					ice (State or Foreign Land
death with the Maryland me 23a or 28a-f show	2000	1	Usual Residence of Decedent 10a. State 10b. County MD Baltim	ore		Town or Lo	116							d. Inside City Limits 1 Yes 2X No
th with the 23a or 2	Filtractor	1	100. Street and Number 11024 Pfeffer	s Road				1087			US.	A	What Countr	
	hy Fire	2	11. Marital Status 1 □ Never Married 2 □ Married 3X Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:				edent of Hisp ecify Cuban, 22 No	panic Origin? (S , Mexican, Puer Specify:	pecify Yes (to Rican, etc	or No- :.)	Bla	ce - America ck, White, e y: Whi	tc.
Z I Z I D-UUSO d within 72 hours after giene. pr then "naturel", or ite.	potologo		15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 8th	lucation de completed) College (1-4or	5+)	16a. Dece (Give life.	kind of v DO NOT		ion ring most of wo	rking			cook	estry Eggnog
and ile	a	2	17. Father's Name (First, Middle, Last) Jake Haupt						8. Mother's Nat	Kamir	ieck	i		
Mar nd 2 sh lith and 27 is m r traum			19a. Informant's Name/Relationship (Charles Hines			220	00 E	Ellen	Avenu	e Par	kvil	le M	ID 21	234
SALTIMORE, permit. Pages 1 at Department of Heal important: If item			20a. Method of Disposition 1	()	Oa K		natorx o	eme tei		Date 1 / 0 6	Ва	ltin	- City or Tow Nore	MD
Departiment import	once.		21. Signature of Funeral Service Licer	1 Come	lly	/ (Conr	elly	of Facility 3	al Ho	me o			
Physicia / /Medic Examin	al		23a. Part1. Enter the disease, or composition of the control of th	plications that cause one cause on each li a Due to (or as	Co	PD	er the m	ode of dying,	such as cardia	c or respirat	ory arrest,			Approximate Interval Between Onset and Death ICOLF
68 / 60, ifficate be executed g physician and as the burial-transit	The state of the s	LYB	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.										
Geath cer death cer e ettendin id for use	Maciolan.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3[]Ectopic] Other (pregnancy specify)					ate of deliver onth E	y Day Year
73			Part II. Other significant conditions of	ontributing to death t	out not resul	ting in the u	nderlying	cause given	n in Part I.		Did tobacco		tribute to the	e cause of death?
of VITAL HECO hysician: The law re his certificate hes bee I director, page 2 sho		Completed									Was an autopsy performed?		Were autop: prior to com death? 1 \(\text{Yes} \) 2	sy findings available pletion of cause of
VITA ician: certific	á	0	25. Was case referred to medical examiner?	Hospital:				Cthor	26. Place of De					
Phys rathis	i	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inju	iry :	P/Outpatier 28b. Time o		28c. Injury a Work?	4 Nuising i		Residence ribe how in		1.7	
DIVISION OF VITAL HECOFIAS, To the Hospital or Attending Physician: The law requires t within 24 hours effer death. To the Funcarial Directors: After this certificate hes been signe completely filled in by the funeral director, page 2 should be a		Cermicanon	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place of In			M reet, fact	1 🗆 Y	es 2 □ No	28f. Local City o	ion (Street a	and Numi ite)	ber or Rural	Route Number,
DIVISIC To the Hospital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the		eolcai	(Check only 2 Medical Examone)	hysician: To the best niner: On the basis of and manner st	of examination	rledge, deat on and/or in	vestigati	on, in my opi	nion, death occ	e, and due to	time, date a	nd place,	and due to t	the cause(s)
To t within To tl		2	29b. Signature and title of contifier	0 6/2	_			19c. License		3		_	ed (Month, D	
į	و		30. Name and address of person who	completed cause of	death (Item 00 Fran	23a) (Type,	Print)	e Driv	60453 e Bell	imore	. Mai	ylan	nd z	21237
Per	State	е	31. Date filed (Month, Day, Year)	32. Regist					•					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment ertificate			Mental Hy	/giene2 (006	20619
	Physic /Medi		1. Decedent's Name (First, Middle, La Sophia L	ILLIAN	AMERI	ESS			2. Date of De Month		2 Year	3. Time of Death 7:30 PM
Àc.	Examir		4a. Facility Name (If not institution, give 5503 Jong u.s.) 5. Social Security Number 4. S.	: Ave	nue	K	Salt	imore funder 24 Hrs	<u>ا</u>		ty of Death	lana (State on Fourier
27.	Funeral Director		Usual Residence of Decedent	□M 2 X F	72 Yrs.	Months		Hours Min.		1934	9. Bittip Coun	lace (State or Foreign litry)
	he Marylau 28a-f show	Director	10a. State 10b. County		Bal-	imo						0d. Inside City Limits 1 Yes 2 □ No
	leath with I	Funeral Dir	10e. Street and Number 5503 Jongui 11. Marital Status	Avenu		10f. Zip (21	1215	Inggifu Van er N	10g. Citizen of	LSA	
900	hours after death with the Maryland tural, or Items 23a or 28a-f show al Exacultaer, ust be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			V	Mexican, Puerl	specify Yes or No to Rican, etc.)	Spec	ify: Americ	
21215-0036	within 72 ene. than "nai	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5	(giv	edent's Usual e kind of work DO NOT use	c done diluri	ing most of wor	rking D n	Balt	Business/Ind	dustry
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	is 1 and 2 sho of Health and Itam 27 is m other traum	3	Informant's Name/Relationship (Aron W. Harkless (20a. Method of Disposition	origgs Day	19b. Mail	New	+tow/	DI	pal Royte Numb	95 Miles 20c. Location	s, Mi	21117
altimore,	permit. Pages Department of Important: if it any injury or o		1 Surial 2 Cremation 3 4 Donatto 5 Other (Specify 21. Signature of Fininal) ervice Licer)	Gamison	matory of oth	Address o	7/2	5/2006	Owing	sell.	Wh. State
8	82553		23a. Part1. Enter the disease, or composhock, or heart failure. List only	plications that caused one cause on each lin	I the death. Do not en	728 L iter the mode	of dying, s	hy Ro., such as cardiac	Randa or respiratory a	ustown.	(M)	21133 Approximate Interval Between
2.07	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. DIFFU		GE B	CELL	(Vm	PHOM	A		Onset and Death MONTHS
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rds, P	w requires that been signed b should be det	ρ	Part II. Other significant conditions of	ontributing to death bi	ut not resulting in the u	underlying cau	use given in	n Part I.	23e. Did t			e cause of death?
Vital Records,	iicien: The law requ certificate has been rector, page 2 shoul	e Completed	25. Was case referred to medical						1 Yes	osy rmed? 2/4 No	prior to com death?	sy findings available pletion of cause of
of Vii	. S . D	To B	examiner? 1 Tes 2 XNo	Hospital: 1 ☐ Inpatie			Cther:	3. Place of Dea 4 ☐ Nursing H		dence 6 □Oth		
Division of	ending eath. or: After he funer	ation	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1.111	Year) 28b. Time of Injury	M 280	c. Injury at Work? 1 Yes	N/A 2 □ No	28d. Describe l	now injury occur	rred	
Ö	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	building, etc	NIA				City or Tov	V/B		
	the Hos	edical	one)	vsician: To the best of iner: On the basis of and manner sta	of my knowledge, deat examination and/or in ted.	th occurred at evestigation, in	the time, on my opinion	date and place, on, death occur	and due to the red at the time,	cause(s) and mi date and place,	anner as sta and due to t	ted. the cause(s)
)	Mith To T	Σ	29b. Signature and title of pertifler	roun M	D.	D	OO /	2599.		29d. Date signe	- 0	ay, Year) 2006
N.C.	10		30. Name and address of berson who dead the state of the	ROWN,	eath (Item 23a) (Type,				PARKAI	RIVE: BI	21.	RE MO.
*	Sta Registr		31. Date filed (Month, Day, Year) JUN 3 0 20	06 32. segistra	r's Signature	mele						10.10

			For State Registrar	State of Marylan		artment rtificate			nd Mental	Hygien	time for the con-	20620
ı	Physici		1. Decedent's Name (First, Middle, Last) L. H. Huskins						2. Date Mon JUN		ay Year	3. Time of Death 1:30P M
	/Medic Examin		4a. Facility Name (If not institution, give					ocation of [4	c. County of Dea	
	Funeral Director		242 22 1100		STEM last birthday) Yrs.	PERR If Under 1 Months		If Under 24	Hrs. 8. Date Min. (Mon Jun	of Righ	FCIL 9. Bir 1918 Nor	thplace (State or Foreign buntry) th Carolina
7 / CNTVCOI	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or Items 23a or 28e-1 show early injury or other treumatic event. The Mudical Examination using a page.	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Harford 10e. Street and Number 2905 Grier Nurse		/, Town or Lo	Fores		el 210	50	10g. C	itizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 No puntry?
5-0036	nours after deat urel', or Items ;	by	1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW 17		1 □ Yes 2[X No	Specify:	i? (Specify Yes Puerto Rican, et		14. Race - Ame Black, Whit Specify: W	rite
2121	ed within 72 h ygiene. ner then "net	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life.	dent's Usual kind of work DO NOT use rakema	done du retired) M	ring most of		Ro	Kind of Business Whoad	/Industry
ryland	should be fill nd Mental Hi marked oth matic even	To Be	17. Father's Name (First, Middle, Last) Grover Huskins 19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailii	na Address (Sara		sley	n Sumame) or Town, State, A	Zin Code)
altimore, Maryland	ages 1 and 2 and 2 and 2 and 2 and 2 and 2 and 27 is in them 27 is and 27 is another 27 is an analysis and 27 is an analysis analysis analysis and 27 is an analysis analysis analysis and 27 is a		Larry Huskins 20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □ F	(SON) 20b. P	781 lace of Dispo	4 Chap sition (Name matory or oth	man of er place)	Road,	Kingsv Date	ille,	MD 210. Location - City or	87 Town, State
ď	permit. Pa Departmen Importent eny injury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			2. Name and	Address	of Facility		ek Fur	ieral Hoi	
INAM	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death le cause on each line. PROSTATE CA Due to (or as a consequ	ANCER		, .			tory arrest,		Approximate Interval Between Onset and Death MONTHS
8760,	certificate be executed rding physician and ise as the burial-transit	icai Examiner	Securitially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a))).								
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Vital Records,	The law ate has b page 2 sł	e Compie	25. Was case referred to medical						1 1	Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of 2 No
Division of Vi	tending Physeath. tor: After this the funeral di	Certification; To Bo	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation be	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At ho	ER/Outpatier 28b. Time of Injury	28d M	Other: Injury a Work? 1 Ye	4 🗌 Nursi	28d. Desi	Residence cribe how injustion (Street a	nd Number or Ru	cify) iral Route Number,
Dİ	= = = =		29a. Certifier 1 Certifying Phys	building, etc. (Specify	wledge, death	n occurred at	the time	, date and p	City	or Town, Stat	(e)	stated
	To the Hospitel of within 24 hours af within 24 hours af to the Funerel D completely filled it	Medical	29b. Signature and title of certifier Leaw hu	ner: On the basis of examinat and manner stated.	ion and/or in	29c. l	icense r	number	occurred at the	29d. Da	ate signed (Monti	n, Day, Year)
j	Sta	ite	30. Name and address of person who co Carolina Custod 31. Date filed (Month, Day, Year)		Maryl	Print)			are Sy			
	Regist		UIN 9 A 2006	Roman B	S. A. Carlot	all the						

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r	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	ath;	4c. County of Dea	th
	The This Hyrkins Hospital Bultimore Ci, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I it Under 24 Hr	<i>ty</i>		
	220-40-8041		^{9. Bir} , 1942 Pen	thplace (State or Fore buntry) nsylvania
.	10a. State 10b. County 10c. City, Town or Location Maryland Harford Street			10d. Inside City Lim 1 ☐ Yes 2X
Dire	10e. Street and Number 10f. Zip Code 211 54	10	-	untry?
1	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
ted D	3 Wildowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	16		nite Industry
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	20a. Method of Disposition 1	Date 20		Town, State
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	McComas Funeral I	Home, P.A.	don MD 2	1009
	23d. Part I. Enter the disease, or comparcations that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	c or respiratory arres	t, 	Approximate Interval Between Onset and Death
77	that initiated events C.			
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	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of deliment	very Day Year
בר ^י	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
			d? prior to co	opsy findings available ompletion of cause of
2	examiner?			
1	27. Manner of Death 1 ★ Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury 28b. Time of Injury 4 Work? 1 □ Yes 2 □ No			ry)
	4 Homicide determined 288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, S	State)	
	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 3 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 3 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 3 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 4 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 5 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 5 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 5 **Medical Examiner: On the basis of examiner: On the basis of examiners and occurred at the time, date and occurred at the	, and due to the caus irred at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
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			For State Registrar	State of	Marylan		artment <i>tificate</i>			and M	lental Hyç	giene Reg. No.	006	20622
			Decedent's Name (First, Middle								2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic	al		Jean Fr		Han⊥ey					June	27	2006	5:00 A. M
	Examin		4a. Facility Name (If not institution		er)			Town, or Ltime	Location o	f Death		4c. Cou	inty of Death	
			3725 Brooklyn 5. Social Security Number		Age (In vrs.	last birthday)	If Under		If Under:	24 Hrs.	8. Date of Birt	h	9. Birth	place (State or Foreign
	Funeral Director		090 24 4019	1 ☐ M 2 💢 F	82	Yrs.	Months	Days	Hours	Min.	Nov. 9,	1923	Ire	land
	ō		Usual Residence of Decedent		10.00	v. Town or Lo								10d. Inside City Limits
	arylar show	<u>-</u>	10a. State 10b. County			Baltimo								1 X Yes 2 □ No
	he Mi	ecto	Maryland N/A		1		10f. Zip	Code				10g. Citizen	of What Cou	ntry?
	with with 1	by Funeral Director	3725 Brookly	n Avenue				212	25			U.	S.	
	death	hera	11. Marital Status	12. Was Deced Armed Forc	ent Ever in U	.S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spo	ecify Yes or No Rican, etc.)	14.1	Race - Ameri Black, White,	
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yla	Ment Marked	2		orge Bell		10h Meili	Add	/Ctranst		Este	al Route Numbe		ailabl	
Maryland	d 2 sh h and 7 is m traum		19a. Informant's Name/Relations Arnold McElroy				Brook							d 21225
	1 and Healt tem 2		20a. Method of Disposition	,	20b. F	Place of Dispo	sition /Nan	ne of	-		Date		on - City or T	
ᅙ	Pages ent of nt: If if		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		are .	en Have	-			6/29	2006	Glen I	Burnie	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Eran and must be notified at once.		21. Signature of Filmeral Service	Licenses			2. Name an				nce Fun ny Balt			e, P.A. land 21225
	*		23a. Part. Enter the disease, o shock, or heart failure. Lis	r complications that can	used the dear	th. Do not en	ter the mod	e of dyin	g, such as	cardiac	or respiratory as	rest,		Approximate Interval Between
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89 ×	taw requires that the death certificate be executed as been signed by the attending physicien and so should be detached for use as the burial-transit.	Physiclan/Med	IF FEMALE:	23c. If yes, outco	ama of progn	2001						204	Data of dala	
Вох	ath ce attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	th 2 □ Feta ntattime of o	aldeath 3[Ectopic pr					230.	Date of delive Month	Day Year
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۵.	res that the de signed by the a be detached t	by PI	Part II. Other significant conditi	ions contributing to dea	ath but not res	sulting in the u	inderlying c	ause giv	en in Part f				/	the cause of death?
rds	w require been sig should b	ted k									10	Yes 2. 2afÑ	lo 3□Pro	bably 4 Unknown
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E R	: The taw cate has	Con									1 Tes	2 No	1 Tes	2 No
Vita	iiclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	patient 2	ER/Outpatie	-1 0 0	Oth	or.		h (Check only come 5 Resident		Other /Snec	60
of	Attending Physician: or death. ector: After this certification by the funeral director,	5. To	1 Yes 2 No 27. Manner of Death	28a. Date of	Injury	28b. Time o		28c. Injur Wor		arsing ric	28d. Describe I			.57
ion	tending leath. tor: After the funer	atlor	1 Natural 5 Pendi 2 Accident invest	ing (Month ligation	, Day Year)	Injury	М		Yes 2□	No				
Division	r Attendi er death. rector: A	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	280. Place (of Injury - At h g, etc. (Speci	nome, farm, st	reet, factor	y, office			28f. Location (S City or Tox	Street and N vn, State)	umber or Rur	al Route Number,
	urs afte	Cer		Sheeking Table	of l	aviladas das	th annumend	at the tir	no data as	nd place	and due to the	causa(s) and	d manner as	etated
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifyl (Check only one)	ing Physician: To the l I Examiner: On the bas and mann	sis of examin	ation and/or in	nvestigation	i, in my o	pinion, dea	ath occur	red at the time,	date and pla	ice, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certific	er n ln				Licens	e number	20		29d. Date si	gned (Month)	Day, rear
	_		Ollum	13 M	un	m 220 17	19 °			7		7	-1/6	6
_	3		30. Name and address of person	B. M	4NF	SES	, Print)	n.	2	372	PoTee	51. B.	AlTo.	nD21225
	St Regist	ate rar	31. Date filed (Month, Day, Yea	006 32. Re	gistrar's Sign	ature	de la							

	1	State	State of Marylan	•	ent of Health a	nd Me		200	6 20623
		Registrar Decedent's Name (First, Middle, Last)			alo ol boalii	3	Reg. 2. Date of Death	NO.	3. Time of Death
Physician /Medical		LAWRENCE	EDWI		tenly		Month	Day Yea 200	6 5:55 AM
Examiner	1	a. Facility Name (If not institution, give st	meet and number)	enter T	City, Town, or Logation of	Death		4c. County of De	A I / A
Funeral Director	0	710 00 000	M 2□ F 7. Age (In yrs.	/ast birthday) If Ur // Mont	nder 1 Year If Under 2 ths Days Hours	Min.	B. Date of Birth (Month, Day, Ye MARCH 4,	ar) 9. E	irthplace (State or Foreign Country) ARYLAND
yland	-	Jsual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Location	2		0		10d. Inside City Limits
death with the Maryland of the 23a or 28a-1 show in must be notified at the most of the characters.		MARYLAND N/	A	101	DALTIMO . Zip Code	RE		Citizen of What	1 ∠ Yes 2 No
23a or	2	3603 HOWA	RD PARI	K	212	207	100	4:	5A.
NCENCE ELMAND HENDER HENDER HENDER 1006, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryla to Health and Mental Hygiene. If item 27 is marked other then "neturel, or items 23a or 28a - 1 show or other traumatic event, the Medical Expriner must be notified at To Re Commissed by Euneral Director	y ruite	1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give	If Yes,	ecedent of Hispanic Orig specify Cuban, Mexican, s 25 No Specify:	in? (Spec Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Ar Black, W Specify:	nerican Indian, hite, etc.
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E1212-00 led within 72 hou ygiene. The Medical Ent. The Medical Ent. The Medical Ent. The Medical Ent.		Elementary/Secondary (0-12)	College (1-4or 5+)		f work done during most Tuse retired)	=0A7	ne	Box	COMPANII
Faryland 2121 2 should be filed within and Mental Hygiene. is marked other then reumatic event, trans. To Reform	0	17. Father's Name (First, Middle, Last)	<i>i1.</i>		18. Mother		First, Middle, Mai	den Sumame)	
Maryland d 2 should be fit in and Mental Hy z' is marked oth traumatic even	2	ANTHONV 19a. Informant's Name/Re tionship (Type		19b. Mailing Add	ress (Street and Number	U I S		ty or Town State	HOMAS
S, Mary and 2 sho lealth and m 27 is m		ADRIENE HENLY	(Daughter)	5606	BRISBANE	0 4	BALT	O. MD	21229
Imore Peges 1 and the point of He intro or other in the intro or other intro or o	1	20a. Method of Disposition / 1 △Burial 2 □ Cremation 3 □ Re	moval from State	Place of Disposition (cemetery, crematory	or other place)	Da	/	. Location - City	or Town, State
Baltimore, N permit. Peges 1 and Department of Health important: if item 27 important: if item 27 once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		UID RIDGE	E (EME) e and Address of Facility SEPH /L	BROG	6-06 B.	ALTIMOR FUNE	RAL HOME
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat cause on each line.	th. Do not enter the	mode of dying, such as o	cardiac or	respiratory arrest.	271, 210,	Approximate Interval Between Onset and Death
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Examiner	5	Sequentially list conditions, b. cause. Enter Underlying Cause (Disease or injury	Due to or as a conseq	uence of):					
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Division of Vital Records, P.O. Box 68760, i or Attending Physician: The law requires that the death certificate be enter death. Director: After this certificate has been signed by the ettending physician in by the funeral director, page 2 should be detached for use as the burial payfilositon. To Be Completed by Physician House and February 15 Be Completed by Physician Record Expendical Expensions 15 Be Completed by Physician Record Expensions 15 Be Completed by Physician Record Expensions 15 Be Completed By Physician Record Expensions 15 Be Physician Record Expensions 15 Be Physician Record Expensions 15 Be Physician Record Expensions 15 Be Physician Record Expensions 15 Be Physician Record Expensions 15 Be Physician Record Expensions 15 Be Physician Record Expensi	ysiciatur	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	 c. If yes, outcome of pregnance 1□Live birth 2□Feta 4□Pregnant at time of continuous 9□Unknown 	il death 3 ☐Ectop	ic pregnancy r (specify)			23d. Date of o	lelivery Day Year
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on of Vita ding Physician: After this certific funeral director.		27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?		d. Describe how i		oeciiy)
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Diversity of the Hospital or within 24 hours elter to the Funeral Direction of the Manager of th	Cal	29a. Certifier Check only one) Certifying Physical Examine	cian: To the best of my knows: On the basis of examination and manner stated.	owledge death occur ation and/or investiga	rred at the time, date and ation, in my opinion, death	h occurred	d due to the caus fat the time, date	e(n) and manner and place, and d	15 stated. ue to the cause(s)
To th within To th comp	ž.	29b. Signature and title of certifier	12	405	29c. License number		29d.	Date signed (Mo	nth, Day, Year)
-1.1	t) Angela K	ropack	עוזו	P18543				7,2006
let 1		30. Name and address of person who con	1/	n 23a) (Type, Print)	areene s	+,	Battir	nore, r	ND 21201
State Registra	4	31. Date filed (Month, Day, Year) JUN 3 0 2006	2. Registrar's Signa						

DHMH 17 Rev 1/2001

Amend item#/,8,9,perffl,635,6/30/06 IT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 2006 **Physician** 28. 4:00AM M Pearl Florence Harp /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Uniontown Road Carroll Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. April 18, 9. Birthplace (State or Foreign MCountry) 5. Social Security Number 7. Age (In yrs. last birthday, 1 ☐ M 2 🖫 F 77 Yrs. 214-26-4511 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🕅 No MD Howard Davton Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4999 Ten Oaks Road 21036 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: White þ 3 □XVidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic 12 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jesse Edward Grimes Jessie Florence Gosnell P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Mrs. Marie Bosley (Daughter) 704 Uniontown Road Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mark's Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 □ Cremation 3 □ Removal from State 6/30/2006 Highland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee PA (B. Sykesville, MD 21784 (410)-795-1400 PA (Box 195) Buar Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of acp line. Date O. Immediate Cause (Final Medical Certification: To Be Completed by Physician/Medical Examiner

/Medical Examiner Division of Vital Records, P.O. Box 68760.

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To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	

Funeral

Director

7 is marked other than "natural", or iteme 23a or 289-f ahow traumatic event, the Medical Examinar must be notified at

and Mental Hygiene.

permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if liem 27 is marked oth any linjury or other traumatic event 9DGB.

Physician

Maryland

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illed within 72 hours after

Baltimore, Maryland 21215-0036

disease or condition		(A Coc				SUEST
resulting in death)	Due to (or as a consec	quence of):		8		- /
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a consec	quence of):				
that initiated events resulting in death) Last	Due to (or as a consect	quence of):				
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1	al death 3 Ectopic p			23d. Date of d Month	elivery Day Year
Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacc		to the cause of death? Probably 4 Junknown
				24a. Was an autopsy performed	orior to death?	autopsy findings available completion of cause of s 2 No
25. Was case referre to medical examiner?				eath (Check only one)		Arrelus
1 Yes, 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 D	OA Other: 4 Nursing	Home 5 ☐ Residence	6 Other (Sp	ecity)
7. Mann of Death 1 Natural 5 ☐ Pending ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njur occurred	HAVE
3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci		ry, office	28f. Location (Street City or Town, St		Rural Route Number,
29a. Certifier (Check only 2 ☐ Medical Examione)	raician. To the best of my kn iner: On the basis of examin- and manner stated.	wledge, death occurrent ation and/or investigation	at the time, date and plan n, in my opinion, death occ	es, and ous to the causa curred at the time, date a	a(s) and manner a and place, and du	as stated. ue to the cause(s)
29b. Signature an the of certifier			63031	29d. i	Date signed (Mor	oth, Day, Year)
Yoush Saffor	ompleted cause of death (ite	South (e	uter Street	WSTHUS	H. DE	21157
31. Date filed (Month, Pay, Year) 20(32/Registrar's Sign	ature force	,			
		ORIGINAL				

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 4a per doc, 10e, 12, 19b, 20a-c, 22 per fh 8857 7-5-06 vin State of Maryland / Department of Health and Mental Hygiene

0625 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** June 23, Hugh Julius Johnson III 2006 2:30 PM /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility North and number) Examiner 101 Oden Hall Avenue #408 Gaithersburg Montgomery 8. Date of Birth (Month, Day, Year) Oct 31, 19 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□F Yrs. 1941 408-70-3801 64 Tennessee Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State ir then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Gaithersburg MD Montgomery 10g. Citizen of What Country? 10e. Street a**Odenehal** 10f, Zip Code within 72 hours after death with 20879 USA 101 Oden Hall Avenue #408 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 賢Yes 空間10 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: black þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene. 5+ program analyst government es 1 and 2 should be filed w of Health and Mental Hygier f Itam 27 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alma Craig Hugh Julius Johnson II 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 05401 192 East Avenue Burlington, VT 05405 Lacretia Johnson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ital any Injury or oth 1 Burial 2 Cremation 3 Removal from State 6-30-06 Edgewood, Md. Kalas Funeral Home, PA, St. 4 Donation Specify) Kalas Crematory Street 20745 21. Si ma are of Eury ral Service L Rona Ld S Director respiratory arrest, Approximated Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclero 10Va5041 Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ending physicien and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical ed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 21 No 24a Was an certificate has 1□ Yes 2□No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XYes 2 □ No 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 (Natural 28b. Time of Certification: 5 Pending investigation 1 Natural 2 Accident efter death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours e To the Funeral C completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ike, lomsko atricia

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 3 0 2005

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤈 🧻 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 11:07AM 2006 6 26 **Physician** JOHNSON Gretel Irena /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville montgomery Casey House 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2-22-1945 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Hours Min. Jamaica 1□M 2∰F Months **Funeral** 61 061-58-7500 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location death with the Maryland 10b. County e filed within 72 hours after death with the Marylan al Hygiene.
to ther then "neturel", or Items 23a or 28a-f show vent, the Madical Examiner must be notified at 10a. State YE Yes 2 □ No Gaithersburg Montgomery MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20882 9726 Ambergate Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Funera 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Specify: Black 1 ☐ Yes 2 🖎 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 δ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker Pages 1 and 2 should be filed a timent of Health and Mental Hygie tent: If tem 27 is marked other t jury or other treumatic event, th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unknown unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9726 Ambergate Ct.Gaithersburg, MD20882 Merleen Green/daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 6-30-2006 Beltsville, MD permit. Page Depertment of Important: If eny injury or once. 22. Name and Address of Facility Silver Spring, MD20910 Rapp Funeral&CremationSvcs.933 Gist Ave. 21. Signature of Funeral Service Licensee mo1358 **(** 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiomyopathy Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit death certificate be executed Diabetes Due to (or as a consequence of) Box 68760, End Stage Renal Disease Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.0. been signed by the sahould be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No this certificate has ral director, page 2 1 Yes 2 No Division of Vital 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HCS PICE 1 Yes 2 No ٩ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After th 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Il Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide within 24 hours aftar or To the Funeral Direct completely filled in by 4 - Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier | Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number certifi 29b. Signatu title c 6/27/2006 D35635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Kaplan 6001 Muncaster Mill Rockville, MD 20855 31. Date filed (Month, Day, Year)

JUN 3 0 2006 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decadent's Name (First, Middle, Last) Year **Physician** 2006 /Medical 4c. County of Death 4b. City ocation of Death Examiner If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min. Months Hours 1 M 2 TOF Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23s or 28e-f show ury or other treumatic event, the Medical Examination in Milled at 1 Nes 2 No Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry TE / Ephone RIZOY Coltege (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ္ OMA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type - rint) 21213 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of 1 Daurial 2 Cremation 3 Removal from Sta Important: If GARRIS *4 ☐ Donation 5 ☐ Other (Specify) TERAN 22/Name and Address of Facility 21. Signature of Funeral Service Litoerisee any in 1814 23a. P rt1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on e Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dving, such as cardiac or respirato Immediate Cause (Final disease or condition resulting in death) **Physician** Nervau /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed attending physician and use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year detached for Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown been signed by to should be detach 23e. Did tobaccq use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy med? 2 No 1 ☐ Yes Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital Other: 1 🗌 Yes 2 € No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 3 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Monner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? After or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Kkaled el-6/29/ 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHA-/L 401 N. DROAD WAY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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State of Maryl	ind / Department of Health and Mental Hygiene

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Funeral	5	Social Security Number 6.	Sex 7. Age	(In yrs, last birth			_	(MM/DD/YYYY) 9. Bi	rthplace (State or
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à	_	Usual Residence of Decedent Oa. State 10b. County		I0c. City, Town	or Location		E - C		10d. Inside City Limits
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Maryland 28a-f show	Director	Oe Street and Number	/7	MIL	TIMOR 10f. Zip Code	<u>ح.</u> •	10g	. Citizen of What Cou	ntry?
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hours after death with the Maryland "natural", or items 23a or 28a-f shr Examiner must be notified at once	75 I I	1. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of	Hispanic Origin? (S ban, Mexican, Puerto		14. Race - Amer White, etc.	ican Indian, Black,
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irs afte	ਠ⊢	15. Decedent's Education (Specify	or Dates:		Decedent's Usual Occu	pation (Give kind of		16b. Kind of Business	
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Z = 2 = 3	0 .	9a. Informant's Name/Relationship		198	o. Mailing Address (St	treet and Number or	Rural Route Numb	er, City or Town, State	e, Zip Code)
md 2 shou calth and 2 shou tem 27 is r		PAULA MITCH	ELC / MOTh	ER 30	002 Els	ABETH A	VE - BAL	<i>To, Ma</i> . 20c. Location - City or	21230
S l and freal of Heal	- 11	20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from Stat						
Imore Pages 1 ment of F tant: If or other		4 Donation 5 Other Spec	rify:	METR	CREMATO	24 7	3/06	BALTO.,	md.
Baltimore bernit Pages 12 Department of H. Important: If it njury or other t	1	21. Signal re of Funeral Service Li	censee	1	22. Name and Addr	ress of Facility	VERN D.	Chomaste	75
Physician	- 1	23a Part I. Enter the disease, or co		he death. Do no	ot enter the mode of dy	ng, such as cardiac	or respiratory arres	it, shock, or heart	Approximate Interval
/Medical	1	failure, List only one cause or Immediate Cause (Final disease	each line. a. Cocaine in	toxicatio	n				Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a consec		4-5				
	ا <u>ه</u>	Sequentially list conditions, If any, leading to immediate	b Due to (or as a consec	quence of):					-
	E	cause. Enter Underlying Cause Disease or injury that initiated	Due to (or as a consec	guence of):					
uted ud ransit		events resulting in death) Last	d.	querioe or).					
760, cate be executed physician and he burial - transi	Medical	X UNPENDED	AMENDED iter	n#23a,27,	28a-f,perME,G	857,7/6/06/	TT		
	2 I/	F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcom		Fetal death	3 Ectopic pregn	0000	23d. Date of deliver	
Box 687 e death certification at the attending of for use as t	ciar	past 12 months?	1 Live birth 4 Pregnant at t	ime of death		3 Ectopic pregit	ancy	Month	Day Year
BO:	≥ _	1 Yes 2 No 9 Unkno	9 Unknown				OO- Did to		0
p.O. that the ned by detach	<u>a</u>	Part II. Other significant conditio	is contributing to death	out not resulting	g in the underlying caus	se given in Part I.		acco use contribute to	bably 4 V Unknown
ords, P	Completed						24a. Was an		utopsy findings available
cor s law r e has b	힐						autopsy perform	ned? death?	completion of cause of
tal Rec	္စ္မို	25. Was case referred to medical			26.PI	lace of Death (Check	1 Yes 2	No 1 ✓ Y	es 2 No
Vital F hysician: this certific	To Be	examıner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	nt 2 🗸 ER/O	utpatient 3 DOA	Other Nursi	ng Home 5 R	lesidence 6 Othe	ır:
n of ding Ph		27. Manner of Death 1 Natural 5 Rendir	28a. Date of Injur (Month, Day,Ye	ry 28b. ear)	, ,	Injury at Work?	28d. Describe ho	ow injury occurred	
Sior Vittend death. ector:	läti	2 Accident S Pendir	gation TIG 0/22/2		9.00 µn	Yes 2 X No	unk	and and blumbar or D	ural Davida Number City
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that th rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Certification:	3 Suicide 6 X Could determ	not be		arm, street, factory, offic	ce building, etc.		621 Franc	is Street
Hospit 24 hour Funer: ely fill		00- 0-dies ==	sician: To the best of my	knowledge, de	ath occurred at the time	e, date and place, an	•		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	蒙	one) 2 Medical Exam	iner:On the basis of exan and manner stated.		nvestigation, in my opir	nion, death occurred	at the time, date ar	nd place, and due to t	ne cause(s)
F S F O	Ĭ	29b. Signature and title of certifier				ense number		29d Date signed (Mo	onth, Day, Year)
		Music		0 /1:		C.M.E.		June 23, 2006	
		30. Name and address of person w Ana Rubio MD. Assi	ho completed cause of de stant Medical Exam		Penn Street, Balti	imore, MD 2120)1		
Sta	ate	31. Date filed (Month, Day, Year)		's Signature	4				
Registi		HIN 3 0 201	16 Braise	15. 16	barle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** ANGELINA
4a. Fecility Name (If not institution, give street and number) JONES 2006 0740 AM MNE 27 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba Himore Johns Hopkins 7 Has If Under 1 Year If Under 24 Hrs. 8. Dat of Birth (Month, Day, Year) 7. Age (In y/s. last birthday) 5. Social Security Number **Funeral** Birthplace (State or Foreign Country) Months Days 1 ☐ M 2 👽 F Director 212-75-8579 05 08 MD 2006 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Executant traumatic event, the Medical Executant traumatic event, the Medical Executant traumatic event. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Y Yes 2 □ No MD NA Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 U.S.A. 6403 Doral Drive Apt B Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: ģ 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) na na na na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Maria Giorgakis William Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6403 Doral Drive Apt B, Balto, Md 21209 Maria Giorgakis-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 7/1/06 Randallstown, Md 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, 21215 and the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTIPLE SYSTEM FAILURE ORGAN weeks /Medical Due to (or as a consequence of Examiner ATRIO VENTRICULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last CANAL DEFECT Examiner Due to (or as a consequence of) sician and X burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown RENAL FAILURE Completed 24b. Were autopsy lindings available prior to completion of cause of death? page 2 s HEPATIC FAILURE 24a. Was an autopsy performed? 1 Yes 2 No 2 No Be director 25. Was case referred to medical 26. Place of Death (Check only one) ဂ္ 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation М 1 Yes 2 No after death Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral C To the Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

600 N. WOLFE STREET BALTMORE

be Willaun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

JULIE WILLIAMSON, DO

RES-000

29d. Date signed (Month, Day, Year)

21287

	_1	For State Registrar	01010 01 111	arytaria /	Certific	ate of	lealth and M Death		Reg. No.	ZUUb	201	53
Dhusisis	_	1. Decedent's Name (First, Middle, Last)		Tohna	\n		2. Date of I Month	Death Day	Year	3. Time of I	
Physicia /Medic	al	Mary			Johnso			06	21	2006	2106	
Examin		4a. Facility Name (If not institution, give			_	-	Location of Death		4c. C	ounty of Death		
			ARITAN			der 1 Year	If Under 24 Hrs.		2 inth	NA 0 Bietho	place (State or	Fore
Funeral		5. Social Security Number 6. Se	X □M 2 X 0F	ge (In yrs. last bi	Yrs. Mont		Hours Min.	(Month,	Day, Year)	Cour	ntry)	1016
Director		226-40-7668 Usual Residence of Decedent		92				7-4-	-13		Va.	
ene. itan "natural", or items 23a or 28a-f show ita Madical Examinar must be notified at	⊢	10a. State 10b. County		10c. City, Tov	vn or Location					1	Od. Inside City	,
ds b	to	Md. NA			Balti	nore					1 🔁 Yes	2 🔲
noti	rec	10e. Street and Number			10f	Zip Code			10g. Citiz	en of What Cour	ntry?	
3a o	Funeral Director	1601 E. Belveder	e Ave.			212	239			USA		
25	ner	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S.	13. Was D	ecedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or Rican, etc.)	No- 1	4. Race - Americ Black, White,		
or the	F	1 Never Married 2 Married	1 ☐ Yes 21 ☐	No		s 3/ No	Specity:		5		lack	
Exp	d by	3X Widowed 4 □ Divorced	Year or Dates:						10) 10			
neti	Completed	15. Decedent's Ed (Specify only highest grad		162	a. Decedent's l (Give kind o life. DO NO	work done	during most of work	ing	160. Kin	d of Business/In	dustry	
than	ф	Elementary/Secondary (0-12)	College (1-4or	5+)	Labo		-,		V	aries		
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Department of Health and Mental Hygiene. important; or items 23s or 28s-f show important: if item 27 is marked other than "natural; or items 23s or 28s-f show eny injury or other traumatic event, it a Nuclical Examinat must be notified at once.	ă	Charles		Harris			Emma			Ellis		
mark matic	ပို	19a. Informant's Name/Relationship (7	ype, Print)		b. Mailing Add	ress (Street	and Number or Ru	ral Route Nur			Code)	
trau		Valerie Greer		daughter			gsway Rd.				1239	
Heal Iem 2 Ither	ŀ	20a. Method of Disposition		20b. Place	of Disposition ery, crematory	Name of	nal	Date	20c. Loc	ation - City or To	own, State	
y or if		1 ☐Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		A .	ng Mem.	_		8-06	Ran	dallsto	wn, Md.	
ortan ortan injur		21. Signature of Funeral Service Licen			22. Nam	e and Addre	ss of Facility	Bal	timore	, Md.	21202	
Depa Impo eny ii		Most.	100000	\sim	Mar	ch F.	H. East			orth Av		
		23a. Part1. Enter the disease, or comp	olications that cause	ed the death. Do	not enter the	mode of dyn	ng, such as cardiac	or respirator	arrest,		Approximate Interval Betw)
л. П		shock, or heart failure. List only a Immediate Cause (Final					0				Onset and D)eath
ysician Medical		disease or condition resulting in death)	a. SEPS	s a consequence	ROBA	364	DUE	TO C	OC, TI	2		
aminer			, ACUT		NAL	FAIL	URE					
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physician and sthe burial-transit	ical	(d									
as th		The second of th										
attending pl	7	1F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Fetal deat	th 3□Ect <i>o</i> c	ic pregnanc	v		2	3d. Date of deliv Month	-	∕ear
the att hed fo	Sicia	in the past 12 months? 1 □ Yes 2 □ No	4☐ Pregnant	at time of death	5 🗌 Othe	r (specity) _			- 1	WOITH	Suy .	04.
ac o	Physician/Med	9 🗆 Unknown		hard mark as the	in the control of		una in Dant I	220 5	id tobacca :::	se contribute to t	ha cause of d	noth.
igned be det	by	Part II. Other significant conditions of	ontributing to death	but not resulting	in the underly	ng cause gr	ven in Paπ I.			/		
been si	ted								: 163 z q			
S CA	Completed							24a. W	itopsy	24b. Were auto	opsy findings a ompletion of ca	avaıla ause
9 8	Con							1 ☐ Ye	erformed? s 2 No	death? 1 🗌 Yes	2 No	
or,	Be	25. Was case referred to medical examiner?	,				26. Place of Dea	ith (Check on	ly one)			
this cerral direct	2	1 Ves 2 □ No	Hospital: 1 Inpa			JOON				□Other (Speci	fy)	
	i.i.o	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Day Year) 28b	. Time of Injury	28c. Inju		28d. Descri	oe how injury	occurred		
or:	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b			M		Yes 2 No	204 Lengtin	n /Ctroat and	i Number or Rur	al Pauta Mumi	har
after d Diract J in by I	Certification:	4 Homicide determined	28e. Place of I	njury - At home, etc. <i>(Specify)</i>	iarm, street, fa	ciory, office			n (Street and Town, State)	, , eumoer or mur	a. noute (Vuiti)	JOI,
urs a eral [200 Codifier 45 Consider 10	veicies. To the best	et of my ke suited	de doort	read at the t	me data and aless	and due to	he causa(a)	and manner as	stated	-
within 24 hours after d To the Funeral Diract completely filled in by	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	nysician: To the bes niner: On the basis and manner:	of examination a	and/or investig	ation, in my	opinion, death occu	rred at the tin	ne, date and	place, and due t	to the cause(s))
thin 2 the imple	Mec	29b. Signature and title of certifier	2.10 (110111101			29c. Licen	se number		29d. Date	signed (Month,	Day, Year)	
N F O		1 Sit a size	190			000	,000		(~	12310	6	
2		30. Name and address of person who	completed course of	f death (Item 22	(Type Dries)	1567	000		_ 9	12010	-	
3			IKAZ WE	5 (A)	I (30 id P	AUFN	BLVA	BALT.	MORE	MA	212	3
	Ļ	T2UKAN 31 S 31. Date filed (Month, Day, Year)	32. R	strar's Signature	COCH W	~	0000	101111	, 131-0	1 112	-1-	_
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permit. Page Depertment of Important: If ony injury or once.	4 Donation 5 Other (Specify) 21. Signature of Funeral Service License			of Fa Name and arch	Address	of Facility	7-3	Balt	imore	imore, e, Md. cth Ave	21202
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quires that in signed by uld be deta	Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the un	nderlying ca	use giver	n in Part I.	-				he cause of death? pably 4 []Unknown
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cian: ertific ector.	25. Was case referred to medical examiner?	1					of Death	(Check only or	16)		
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tal or Attending P is after death. al Director: After t ed in by the funera Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre y)					8f. Location (S. City or Town		lumber or Rura	al Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in I Medical Cert		ner: On the best of my kno ner: On the basis of examina and manner stated.									
within 2 To the complet	29b. Signature and title of certifier			29c.	License	number		2	9d. Date s	igned (Month,	Day, Year)
4		n Yosdovitz, MD	,		RES	5-000		ļ	Ju	r 25,	2006
2	30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type, F วิเกณ H		1 08	Ba	Him	ere.			

DHMH 17 Rev 1/2001

Ida Thomton

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month O **Physician** Year 2006 Jennings /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore University Specialty If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2X F Days Hours 86 Director 06 052-24-3958 SC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show tre Medical Examiner must be notified at 1 XYes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3905 Annellen Road 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: X Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 Widowed 4 Divorced Black is marked other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Domestic Worker Private na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be Lee Jennings Annia Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) perriit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau snc. Dorothy Jennings-Daughter 3905 Annellen Road, Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) King Memorial Park 7/1/06 Randallstown, Md Signature Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 1. Enter the disease, or complications hal caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeriate Cause (Final disease or condition resulting in death) **Physician** Chronic obstructive YVI. /Medical Due to (or as a consequence of) Examiner 6minth 4do ma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the attending physicien and hed for use as the burial-transit certificate be executed perfect that initiated events resulting in death) Last Due to lo las a consequence of) hi Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown as been signed by t 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Hriknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? this certificate 1 Yes funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

Registra

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Division of Vital

Annie

31. Date filed (Month, Day, Year) JUN 3 0 2006

29b. Signature and title of certifier

melitam

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(HARE MEHTA, MD, 611 so charles Street, Baltomore, MD 21930 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

		4	For Stete Registrar	State of M	aryland / Dep	artmen e <i>rtificat</i>	t of He	ealth a Death	nd Me	ntal Hy	giene Reg. No	4	5	206	33
- #	Physici	an	1. Decedent's Name (First, Middle, Last)						Date of De Month	Day		ear	3. Time of	
	/Medic	al	Andrew August Kro	-		1 0	T			une 26		006 County of I	Dooth	11:48	3 P [™]
	Examin	er	4a. Facility Name (If not institution, give Millennium Health					Location of City			40.			a	
		30,00%	5. Social Security Number 6. Se		ge (In yrs. last birthda	y) If Under	1 Year	If Under 2	4 Hrs. 8.	Date of Bi	rth	9	Ward Birthpla	ace (State o	r Foreign
	Funeral Director			XM 2□F	91 Yrs.	Months	Days	Hours	Min.	Month, Di	ay, Year)	915 M	Count	Iand	
4	70		Usual Residence of Decedent		1									24 12-14- 01	h. I imika
	arylar	_	10a. State 10b. County		10c. City, Town or Catons								10	0d. Inside Cit	
	189-1	Directo	Maryland Baltimore	=	Catons	10f. Zip	Codo				10a Cit	izen of Wha	at Count		X
	with the or 2	급	1201 Brandford Ro	Ьe			21228				rog. On	USA	at Court	ny:	
	eath	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13	3. Was Dece	dent of His	panic Orig	in? (Specif	fy Yes or N	0-	14. Race -			
(0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Itam 27 is marked other than "natural", or Items 23a or 28e-f ahow any injury or other treumatic event, I'm Madical Exacultual must be multified at once.	Funeral	1 Never Married 2 Married	Armed Forces	?	If Yes, spe	cify Cuban	, Mexican,	Puerto Rio	can, etc.)			White, e		
21215-0036	ral', o	d by	3 XWidowed 4 ☐ Divorced	If Yes, Give ** Year or Dates:		1 🗆 Yes	2 <u>M</u> 190	Specify:				Specify:	Wh:	i te	
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П	Hygie Hygie ther I	ပိ	17. Father's Name (First, Middle, Last)	<u> </u>	Gas	Maker		18. Mother	's Name (/	First, Middle					
Maryland	d be f ental } kad ol	To Be	Andrew A. Kroeger	, Sr.				Marg	aret	Beyer					
ary	shou nd M mar	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Ma	iling Address	(Street a	nd Number	r or Rural P	Route Numb	er, City	or Town, Sta	ate, Zip	Code)	
Ž	alth a alth a 27 is		Carolyn A. Schuet	rum / dau	ghter 731	Wilton	n Far	m Dri	ve, C	Catons	vill	e, Md	l. 2	1228	
altimore,	of He		20a. Method of Disposition 11/2 Burial 2 Cremation 3	Domousi from State	20b. Place of Dis	position (Nai	me of other place)	Dat	.0	20c. L	ocation - Ci	ty or To	wn, State	
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8760, 🥦	death certificate be executed e attending physician and dor use as the buriat-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):										
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isic	Attending r death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		njury - At home, farm,			- 2		f. Location	(Street a	nd Number	or Rura	I Route Num	nber.
Division	l or Attendated after death Diractor:	Certification:	4 Homicide determined	building, e	tc. (Specify)	51.551, 120151	,, 000			City or To					,
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	To the within 2 To the complet	₩	29b. Signature and title of certifier	1 //	/11/	29	c. License	number			29d. Da	ate signed (Month, I	Day, Year)	21
			1	/	me		WS"	27	46		Tres	NP,	28	,20	06
	13		30. Name and address of person who	completed cause of	death (Item 23a) (Typ)	oe, Print) Zflen	Ch	esica	e lo	al	fe	lf	u	1021	22F
4	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 3 0 2	32. Regis	trar's Signature	Coast	9								

			- State Amend Item 29d	te of Marylan per Dr.,G	id / Depa 856 ,06 /	artment of H 730/06dhb Hilicate of t	ealth and M Death	lental Hyg F	giene 2 0	06	20634
	Dhuaiai		Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Year	3. Time of Death
	Physici /Medic		Shirley E. Kelba					June 20	-		2:35 P. M
1	Examin	er	4a. Facility Name (If not institution, give street 4305 Newport Avenue				Location of Death		4c. County o		
	Funeral		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs.	last birthday) Yrs.	II Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	v, Year)	Coun	
	Director		Usual Residence of Decedent	00				Oct. 22	2,1919	Mary	yland
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo					10	0d. Inside City Limits
	e Ma	cto	Maryland N/A		Balt	imore					M∏Yes 2 ∏No
	h with th	Funeral Director	10e. Street and Number 4305 Newport Avenue			10f. Zip Code 2121	1		10g. Citizen of W U	hat Coun SA	try?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show eny injury or other traumatic svent, the Medical Examination must be notified at once.	ρ	1 Never Married 2 Married 1	as Decedent Ever in U med Forces?] Yes 24340 'es, Give ar or Dates:		Was Decedent of Hi II Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	- Americ k, White, k Whit	etc.
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7	iled w Hygier ther th		12 17. Father's Name (First, Middle, Last)		EX	ecutive A	SSISTANT 18. Mother's Name	e (First Middle	Insural		Company
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ary	shour and M mari	-	19a. Informant's Name/Relationship (Type, Pr	int)	19b. Mailir	ng Address (Street a	and Number or Rura	al Route Numbe	r, City or Town, S	State, Zip	Code)
	and 2 selth a n 27 is		Joanna Handley Gran		-	Falls Ro			Maryland	2121	1
ore	Pages 1 nent of He ant: If its		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov		Place of Dispo cemetery, crer	sition (Name of matory or other plac	θ)	Date .	20c. Location - (City or To	wn, State
Baltimore,	t. Pag rtment rtant:		4 Donation 5 Other (Specify)	Me		ematory	6/28/				Maryland
Bal	permi Depa Impo eny is		21. Signatur of Funeral Service Licenses	nss	Bi	Name and Address urgee—Hen 631 Falls	ss-Seitz Road, Ba	Funeral altimore	Home, 1	Inc.	21211
	Physician		23a. Part1. Enter the disease, or complication shock, of heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	s that caused the deat se on each line.	h. Do not ent	er the mode of dyin	g, such as cardiac (or respiratory ari	rest,		Approximate Interval Between Onset and Death
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ion	Attending Phir death. ector: After the by the funeral	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		<br Yes 2 □ No				
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	To the Hospital or At within 24 hours after or To the Funerel Directompletely filled in by	ledicai C	29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner: Cartifying Physician 2 M	To the best of my kno n the basis of examina nd manner stated.	owledge, death	h occurred at the time vestigation, in my op	ne, date and place, pinion, death occurr	and due to the o	cause(s) and mar date and place, a	ner as stand due to	ated. the cause(s)
	To the leadth 2. To the leadth 2. To the leadth 3. Complet	Me	29b. Signature and title of certifier	ven	1	29c. License	2307 (June 22		,
	(b)		30. Name and address of person who completed R is charal Diamond	MM. 373	10 Fa	Print) US Rd.	Balto	5. Md.	21211		
	Sta Registi		31. Date filed (Month, Day, Year) JUN 3 0 2006	32. Registrar's Signa	Soa	the same					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No.-2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4:50 A M **Physician** June 27,2006 CHARLES JOSEPH KIRCHNER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 4, 1924 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 218-12-2449 1 **X**M 2 ☐ F 81 Yrs. Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent, the Madical Examinar must be notified at MD Anne Arundel Glen Burnie 1 ☐ Yes 2 X No Funeral Direct 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? 308 Delaware Avenue 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White à 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7. h and Mental Hygiene. 7 is marked other than *n International Union Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator Of Operating Engineers 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charlotte C. Parr Edward G. Kirchner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Depertment of Heelth and Important: If Itam 27 ia m any injury or other traum odes. David Gregory Kirchner-son 2417 Hess Road-Fallston, Maryland 21047 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Glen Haven Cemetery 6-30-06 Burnie, MD 1 Burial 2 Cremation 3 Removal from State Glen 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility EVANS FUNERAL CHAPEL 3 Newport Drive-Forest Hill, MD 21050 21. Signature of Funeral Service Licensee andral add 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DURRID **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 200 No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes To Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🛇 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Diractor: After this in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medicai Certification: Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours eff To the Funeral DI completely filled in 1 Certifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cauce(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0063220 GEORGE ISCHARUS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 CFIESAPEAKE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registrar

			, FOI	partment of Health and Menta ertificate of Death	Hygiene Reg. No 0 0 6	20637
	Physicia		Decedent's Name (First, Middle, Last) Carolyn J. Kelly	2. Date June	e of Death 1th 28, 2006 Year	3. Time of Death 8:00 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4400 4th Street Apt. 1	4b. City, Town, or Location of Death Baltimore	4c. County of Death Anne Aruno	
	Funeral Director		5. Social Security Number 285-34-1145 6. Sex 1 □ M 2 □ F 7. Age (In yrs. last birthda Yrs.	y) If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. 1 19	of Birth 9. Birth 12/1939 OH	place (State or Foreign intry)
	aryland show	<u>.</u>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
;	with the Ma a or 28a-fi be notifie	Directo	MD Anne Arundel Baltimor 10e. Street and Number 4400 4th Street Apt. 1	10f. Zip Code 21225	10g. Citizen of What Cou USA	
936	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: if tien 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Executive must be notified at ODGe.	by Funeral Director	-	. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e 1 ☐ Yes 2 ☑ No Specify:		, etc.
Maryland 21215-0036	within 72 hor ane. then "natura	Completed	(Specify only highest grade completed) (Girling (1.4or 5.)	sedent's Usual Occupation ve kind of work done during most of working . DO NOT use retired) stered Nurse	16b. Kind of Business/li Hospital	ndustry
land 2	should be filed and Mental Hygis e marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Last) Joseph George Kakascik	18. Mother's Name (First,) Sophia	Middle, Maiden Surname)	
Mary	nd 2 shou alth and M 27 ie mar ir treumat			iling Address (Street and Number or Rural Route) 4th Street Apt. 1 Bal		
Baltimore,	Pages 1 and 2 nent of Health ent: If item 27 i ury or other tre		1 Rurial 2 PCremation 3 Removal from State cemetery, ci	position (Name of Pate Genatory or other place) ake Crematory 2006	30 Beltsville, 1	
Balt	permit. Page Department of Importent: ff any injury of once.		Inda Ince Ruther MO1443	22 Name and Address of Faultheral Alt 8717 Green Pastures Drive	Baltimore, Mar	yland
8760,	Cate be executed Wedical Wedical Examiner The buriat-transit	dicai Examiner	23a. Part. Efter the disease, or complications that caused the death. Do not eshook, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	OBSTRUCTUE DISE		Approximate Interval Between Onset and Death YEATS
P.O. Box 6	The law requires that the death certific are has been signed by the attending page 2 should be detached for use as I	Physician/Me		B ⊟Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of deliv	very Day Year
rds, P.	w requires that i been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 238	Did tobacco use contribute to 1	the cause of death?
l Reco	The law recate has be page 2 sh	Completed			a. Was an autopsy performed? Yes 2 100 24b. Were autoprior to condeath?	opsy findings available ompletion of cause of 2 No
Division of Vital Records,	To the Hospitel or Attending Physician: The la within 24 hours after death. To the Funeret Director: After this certificate has completely filled in by the funeral director, page 2	Certification; To Be	25. Was case referred to medical examiner? 1	of 28c. Injury at Work? M 1 Yes 2 No 28d. Des	scribe how injury occurred ation (Street and Number or Run or Town, State)	
	ne Hospite 7 24 hours Ne Funerel Netely filled	edical C	29a. Certifier (Chack only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due investigation, in my opinion, death occurred at the	to the cause(s) and manner as a time, date and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of gertifier MOMP	29c. License number	29d. Date signed (Month)	
	5		30. Name and address of person who completed cause of death (Item 23a) (Typ Defense I+W Y S V) T 31. Date filed (Month, Day, Year) JUN 3 0 2006 32. degistrar's Signature	B. Print) E 400 ANNAP	OLIS MD	21401
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 3 0 2006	padi		

			1 - For State Registrar	State	of Ma	arylan	d / Depa			ealth a Death	and M	ental H	ygier Reg. 1		06	20638		
			Decedent's Name (First, Middle	e, Last)								2. Date of D	eath			3. Time of Death		
Phy	sicia edic		Martin	F.		Kur	er, Jr					June 2	5,	2006	Year	10:00 p M		
	min		4a. Facility Name (If not institution	-	u <i>mber)</i>			4b. City,		Location o				4c. County				
			Stella Maris						-	Val				Balt:				
Fune Direc			5. Social Security Number 213-16-4429	6. Sex 1 M 2 □ F	7. Ag	85 (In yrs.	Yrs.	Months	Days	If Under a	Min	8. Date of E (Month, L April	Sirth Day, Yea	1921	Cou	place (State or Foreign oftry) 1 Land		
and *		}	Usual Residence of Decedent 10a. State 10b. County			10c. Cit	y, Town or Lo	cation								I Od. Inside City Limits		
Marylan f ehow		ō	Maryland N/A			Balt	imore									1X Yes 2 No		
r 289		Director	10e. Street and Number					10f. Zip	Code				10g.	Citizen of V	What Cou	ntry?		
th wit			4010 Belwood	Avenue				2	1206				I	USA				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked or other then "natural", or iteme 23a or 28a-1 ehow within the Year and the Year marked with the temperature.		/ Funeral	11. Marital Status 1 ₹ Never Married 2 Mar	If Yes	Forces? 2 □ 1 Sive	40	_ '	Vas Dece Yes, spe I□Yes	cify Cubar	spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto f	cify Yes or N Rican, etc.)	10-	Blac	e - Americk, White,			
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e file othe		Be C	17. Father's Name (First, Middle,	Last)						18. Mothe	r's Name	(First, Midd	le, Maio	len Surnam	16)			
Menta Menta		2	Martin	F.			Kuper			Anı	na			Voe	ermar	ın		
2 sho and is m			19a. Informant's Name/Relations				19b. Mailir	g Address	(Street a	nd Numbe	r or Rura	Route Num	ber, Cit	y or Town,	State, Zip	Code)		
1 and Health em 27			Charles M. Her	nkel (Nep	hew)		305 W			., На		ead,				State .		
Pages 1	5		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation		n State	С	emetery, crer don Pa	natory`or o	other place		6/29			Location -	-	laryland		
it. Pa			4 □ Donation 5 □ Other (S 21. Signature of Funeral Service			Lou	The second second second			-								
Dep 1	once		21. Signature of Fullstan Service	Electrisco								lon Pa Balti						
			23a. Part Enter the disease, o shock, or heart lailure. List	r complications that only one cause on	caused each lir	the death	n. Do not ent	er the mod	le ol dying	g, such as	cardiac o	r respiratory	arrest,			Approximate Interval Between Onset and Death		
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		E.	Sequentially list conditions,	b. — Due to	o (or as	a cons	uence oil:											
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nd ph	8	Med	IF FEMALE:	W	715-75-5	1000												
that the death certific ed by the attending p	5	hysician/Med	23b. Was decedent pregnant in the past 12 months?		birth	2 Feta	Ideath 3	Ectopic p						23d. Dat Mor	e of deliventh	ory Day Year		
be de de de de de de de de de de de de de		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pre		time of d	eath 5∟	Other (sp	xecity)									
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ysical residual resid	5	To B	examiner? 1 ☐ Yes 2 X No	examiner? 1 ☐ Yes 2 ▼ No Hospital: 1 ☐ Inpatient 2 ☐ ER/O							Other							
Mert			27. Manner ol Death 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) Injury						f 28c. Injury at 28d. Describe h Work?						how injury occurred			
tendi leath.	D	cati		not be	11-1	41.5		М		/es 2 □ l		01 1	(0)					
or All	r r	ertification;	4 Homicide determ	nined 288. Pla	ding, et	ury - At no c. (Specif	ome, farm, str v)	eet, factor	y, office		2	City or T	own, St	ate)	er or Hura	al Route Number,		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funceral Director: After this certificate has a controlled in the functor of the control of the formula of the functor of the control of the functor of the control of the functor of the control of the functor of the control of the functor of the control of the functor of the control of the contro	2	O	29a. Certifier 1 K Certifyi	ng Physician: To t	he best	of my kno	wledge deat	occurred	at the tim	e, date an	d place, a	nd due to th	e cause	(s) and ma	nner as s	tated		
Hos 24 h	(alai)	edicai	(Check only 2 Medical one)	Examiner: On the	basis of	examina	tion and/or in	estigation	, in my op	inion, deal	th occurre	d at the time	e, date a	and place, a	and due to	the cause(s)		
To th To th	dip	Me	29b. Signature and title of sertifie	or				29	. License	number			29d. l	Date signed	(Month,	Day, Year)		
)1	-				-	DC	137	25			6/2	6/0	6		
inx	1		30. Name and address of person	who completed ca	use of d	eath (Iten	1 23а) (Туре,	Print)						-	100			
10,			DR. TARIQ MAHM				Y VALL	EY RD	. T	IMONI	UM,	MD 210	93					
Red	Sta gistr		31. Date filed (Month, Day, Year,	0 2006	100	ar's Signa		Local	19									

DHMH 17 Rev 1/2001

JUNE 25, 2006 10:00 p.m.

ORIGINAL

			For State Registrar		State	of Ma	rylan		partme ertifica				lental H		ene 2 0	06	20	639		
	Observated:		1. Decedent's Name	e (First, Middle, La	ist)								2. Date of Month	Death	Day	Yeer	3. Time of	Death		
Н	Physicia /Medic		Soon Ma	n Kim									June	27,	2006		1:45	Z₩.		
7	Examin		4a. Facility Name (II	_						y, Town, or					4c. County	of Death				
			Ellicott			_		la a k laskada		icott er 1 Year		<i></i>	0. D-11. of		Howard					
П	Funeral Director		 Social Security N 217-94-26 		Sex 1 □ M 2 ∏ F	7. Age	78	last birthda Yrs.	Month		Hours	Min.		Day, Y		Cour		r i-oreign		
			Usuel Residence of				70						10/26	1/19	28	Kore	a			
	yland		10a. State	10b. County				y, Town or								1	0d. Inside Cit			
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	or 28	Dire	10e. Street and Nur							ip Code				100	, Citizen of		ntry?			
eath	be filed within 72 hours effer death with the Maryland ital Hygiene. Id other then "natural", or items 23e or 28a-f ehow event, the Medical Examiner must be motified at	Funeral Director	10244 Red	d Lion Ta				6 1		.042		1-1-0 (0-1	-4 V	No		USA	an Indian			
	Item Iner	-u	11. Marital Status 1 □ Never Marri	ed 2 Married	12. Was De Armed F	orces?		5.	If Yes, s	ecify Cuba	in, Mexica	n, Puerto	ecify Yes or Rican, etc.)	140-		ce - Americ ck, White,				
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ğ	2 hou	Completed	/5000	ducation	cation 16a. Dece			cedent's U	sual Occupa	ation	et of words		16	ib. Kind of B	. Kind of Business/Industry					
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			21. Signature of Fu				124		•							•				
Baltimore, N xecuted M > 1	on in page		21. Signstone of Suneral Service Licensee 22. Name and Address of Facility L. Kauffman Funeral Home at Meadowridge Memorial Park, I 7250 Washington Blvd., Elkridge, MD 21075												k, IV					
			23a, and 1. Enter the disease, of conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between												veen					
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5	w require been si should	eted												Yes	2 No	3 Prob	ably 4 □U	nknown		
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<u>o</u>	nding ith. r: After e funer	tiol	27. Manger of ☐eath 1								No									
VIS	or Attendation of Director:	E C	Suicide G Could not be determined Hornicide Hermicide See Place of Injury - At home, farm, street, factor building, etc. (Specify)							et, factory, office 28f. Loc					Location (Street and Number or Rural Route Number, City or Town, State)					
	s after al Dire	Certification;	4 🗆 Homicide		, Dan	dirig, etc.	(Specil)	′)					City of	rown, s	otate)					
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only	1 ☐ Certifying Pi 2 ☐ Medical Exa	hysician: To the	ne best of	my kno	wledge, de	ath occurre	d at the tim	e, date ar	nd place, a	and due to t	he caus	se(s) and ma	anner as st	ated.			
	To the H within 24 To the F complete		one)		and ma	nner state	ed.						Da at the ter							
	or ¥ or po	Σ	29b. Signature and	title of certifier					2	9c. License		1			Date signe					
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	3		30 Name and address		completed car	use of dea	ath (Item	23a) (Typ	Print)	Wel M	Jock	Rot	d Ba	1/	mm	May	yland 2,	1221		
	Sta	10	31. Date filed (Mon.			Registrar	's Signa	ture A	KK	V4 /1	y C C ~	, ac	- 124	-]	1141		11-21 0			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#12,perFl. 0856 (120 Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year Month **Physician** KULP HARRY 1204 PM June 7006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital OF Baltmore Baltomore Months Days Hours Min. 8. Date of Birth 05/24/1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country ERMANY **Funeral** 1 M 2□ F 76 Yrs Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 2 should be filed within 72 hours and Mental Hygiene.
1s marked other then "neture!; or itema 23a or 28a-f show
1s marked other, the Medical Exacidinar trials for neither an 10a. State 10b. County 10c. City, Town or Location RANDALLSTOWN BALTIMORE MD 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21133 3708 COLLIER ROAD 12. Was Decedent Ever in U.S. Amed Forces?

1 1 Yes S No. If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc.
WHITE 1 Never Married 2 Married 1 ☐ Yes 2 No Specify δ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ACCOUNTANT ACCOUNTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **KULP** ILSE ROTHSCHILD MAX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
importent: if item 27 is
eny injury or other trau 3708 COLLIER ROAD - RANDALLSTOWN, MD 21133 ANITA KULP / WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State CHEVRA AHAVAS CHESED 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/29/2006 RANDALLSTOWN, MD SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Tour 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Due to (as a consequence of): /Medical Examiner Dotansiv Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): signed by the attending physicien and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 □Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown been si Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2. 1 ☐ Yes 2 26. Place of Death (Check only one Other: 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Tyes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number MD BS 9316527

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Maryland 21215-0036

Baltimore,

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of Vital

State Registrar Matthaw D. Sm. H 31. Date filed (Month, Day, Year) 32. Refistrar's Signature JUN 3 0 2006

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

Smith Smai Hospital

strais Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Lawson Donald 8:04a.m 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mountwashington Pediatric 5. Social Security Number 219-73-0613 6. Sex 7. Age (In yrs. la birthday) If Under 1 Year Baltmore If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 219-73-0613 Yrs. Director Maryland 10/21/05 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Yes 2□ No Maryland Director NA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1708 W. Rogers Ave. 21209 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1∐ Yes 2ŶXÎNo Specify: Completed by 3 Widowed 4 Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Infant Infant NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald Pearson Parthenia Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra once. Parthenia Lawson Mother 927 N. Washington St., , Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Mem. Park 6-30-06 Randallstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Acidosis Examiner Completed by Physician/Medical Examiner POVO or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nding physician and Division of Vital Records, P.O. Box 68760, iar Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to tha causa of death? 21, Complex congenital heart disease, 1 ☐ Yas 2 No 3 □ Probably 4 □ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? pothyroidism, Ventilator dependent chronic lung disease 1 ☐ Yes 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 (Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation I Director: A 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00060119 06/24/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tamara Burgunder, MtWashingten Pediatricthspital, 1708 W. Rogers Ave Battmore
Date filed (Month, Day, Year) 32/Registrar's Signature Maryland 21/209

DHMH 16 Rav 6/95

State Registrar

31. Date filed (Month, Day, Year)

06-04395

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Linwood B. Lockett Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ June 23, 2006 0944 hrs Lockett Bobby Linwood Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 2525 Francis Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Hours Country) N.Y. 123-38-4909 1 X M Director 10-31-1949 2 56 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 X Yes 2 23a or 28a-f show notified at once. Balto N/A hours after death with the Maryland Md 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21217 2525 Francis Street 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. Funeral 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 Married Yes 2X No or. Black Yes 2 X No specify: Specify If Yes, Give Yea 4 X Divorced Widowed ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bayview Hospital Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene.
ant: If iten 27 is marked other than "n r other traumatic event, the Medical E Registered Nurse Baltimore, MD 21215-0036 2 years 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosa Brown Be Otis Lockett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ 1321 Eden Street Apt 2 Balto, Md Tyrone Lockett - Son 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Lawrenceville, Va 6-30-2006 Brown Cemetery Department o Other Specify Donation 5 0 22. Name and Address of Facility March F/H 21. Signature of Funeral Service Licenses West 4300 Wabash Avenue Balto, Md 21215 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Death Medical Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medical physician the burial -UNPENDED AMENDED To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Month Fetal death 3 Ectopic pregnancy Live birth use as t past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown icate has been signed by the page 2 should be detached fi Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. þ Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed' 2 No Yes 2 V No 26 Place of Death (Check only one) director, 25. Was case referred to medical Hospital: Other₄ examiner? DOA Nursing Home 5 Residence 6 ✓ Other: Scene Inpatient FR/Outpatient 3 this 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 V Natural Yes 2 No Director: , d in by the f Pending 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 24 hours To the Funeral 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 29a. Certifier 4 Wedical 2 V Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie June 23, 2006 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner

State

Registrar

31. Date filed (Month i Day, Year)

32. Registrar's Signal

2006

Amend Item 1 per dr., g878, 04/09/08dhb Amend Items 23d, Pt1, II, 25 per ME, C356, 06/29/06din All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registrar MEND#1perMD5/24/06, BWW, MbCo Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Guillermo Alfredo Martinez Month **Physician** 1145 AM May 20 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Maryland Medical Cents Baltimore NIA If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6-24-1942 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral 1 ★M 2 ☐ F 63 El Sälvador 218-53-7974 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r then "natural", or iteme 23s or 28s-f show the Medical Examinar must be nutitled at Prince George's Hyattsville 1 ☐ Yes 2X No MD Direct 10g. Citizen of What Country? 10e. Street and Number 7216 Westpark Drive 10f. Zip Code 20783 El Salvador Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 XYes 2 □ No Specify: δ 3 ☐ Widowed 4 ☐ Divorced El Salvador Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other then College (1-4or 5+) Elementary/Secondary (0-12) Construction Painter 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event 9008. Lidia A.Martinez Juan F. Monterroza 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7216 Westpark Drive Hyattsville, Md. 20783 Danny Martinez/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Gate of Heaven 5/23/06 Silver Spring, Md 4 ☐ Donation /5 ☐ Other (Specify) 21. Signature of Funeral Service Licens PHILTY AUSRINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Seizures Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Right temporal-parietal hematoma Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit N APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Box 68760 physicien Be Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No signed by the atte 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Renal disease, Cirrhosis, Ascities 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan page 2 s autopsy performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 10 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) After this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.
To the Funeral Director: All completely filled in by the fu investigation 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0

State

Registrar

5. Greene St

32. Registrar's Signature

2006 Delegue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

Zilioli

31. Date filed (Month, Day, Year)

P18578

Bultimore, MD 2120

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Baltimore,	permit. Pages 1 an Department of Heali Importent: If item 2 any injury or other 2005.		21. Signatur of Funeral Service Library R. Gregory Phrk MO1148 22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S, Glen Burnie, MD 21061													
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39 ×	The law requires that the death certificate be executed its has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Med	IF FEMALE:	If you gutoome	of acassass					-		-				
Вох	attenc for us	Physician/Me	in the past 12 months?	 If yes, outcome a 1 ☐ Live birth 4 ☐ Pregnant at 	2 Fetal death 3	∃Ectopic pr ∃ Other (sp						ate of deliving the state of th	•	ear		
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	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: Atter this certificate ha completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
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			30 Name and address of person who com	L GW	eath (Item 23a) (Type,	Print)	o M	1,6	LEN	BUPN	te in	020	36)			
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Baltimore, Maryland 21215-0036	1 and 2 Health ar 6m 27 le		Dary Mayes / 20a, Method of Disposition		Place of Dispo	sition (Name	-		c. Location - City or	
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量	rtmer rtent rtent njury		* 4 □ Donation 5 ☑ Other (Specif			2 None and	Address of South			
Ba	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show eny injury or other traumatic event, I'm Medical Exprimer mail for multified at once.		21. Signature of Funeral Service Liber Ronald	Wade, Director			-	d 655 W. B	Baltimore	Street
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E			shock, or heart failure. List only	one cause on each line.				ac or respiratory arres	τ,	Approximate Interval Between Onset and Death
- 15	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Pre	mate	urity			1 hour
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		7	Sequentially list conditions,	b. Due to (or as a conseq	uence of):					
	ted nsit	u u	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0.00 (0.00 0.00)	301100 01).					
	and al-tra	Examiner	resulting in death) Last	cDue to (or as a conseq	uence of):					
760,	eath certificate be executed attending physicien and for use as the burial-transit	cal								
189				d						
Вох	certi nding use a	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of de	livery
m	d for	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregi Other (speci			Month	Day Year
P.O.	that the de ed by the a detached t	Physician/Med	9 □ Unknown	9□ Unknown						
ري ح	res tha igned I be det	by P	Part II. Dther significant conditions of	ontributing to death but not res	ulting in the u	nderlying cau:	se given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Vital Records,	quire in sig uld b	pe pe						1 ☐ Yes	2 ∑ 0 3 □ P	robably 4 Unknown
00	law requir as been si 2 should	Completed						24a. Was an	24b. Were a	utopsy findings available
æ	i cian: The lav certificate has ector, page 2	E O						autopsy	d? death?	completion of cause of
ta	un: J	Be C	25. Was case referred to medical				26 Place of D	1 Yes 2 ath (Check only one)	No 1 Yes	2 □ No
	ysici is cer direct	0	examiner? 1 ☐ Yes 2 📆 o	Hospital: 1 Impatient 2	ER/Outpatien	nt 3 DOA	Othor	Home 5 Residence	ce 6 DOther (See	cutu)
Division of	g Physer this seral di	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		Injury at	28d. Describe how		ony,
0	nding F ath. r: After e funer	atlo	1 Aatural 5 Pending 2 Accident investigation		Injury	М	Work? 1 ☐ Yes 2 ☐ No			
<u>Vis</u>	l or Attendi after death. Director: A	ifle	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, o	ffice	28f. Location (Street	et and Number or R	ural Route Number,
Ö	s after of Direct	Certification;	Tiomicide	building, atc. (Spacin	y/			City or Town, S	State)	
	To the Hospitel or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending photo the Funeral Director: After this certificate has been signed by the attending photo the funeral director, page 2 should be detached for use as the		29a. Certifier 1 ertifying Ph	ysician: To the best of my kno	wiedge, death	n occurred at	the time, date and place	e, and due to the caus	se(s) and manner as	s stated.
	in 24 he Fi he Fi	Medical	one,	niner: On the basis of examina and manner stated.						
	To the Hospitel within 24 hours a To the Funerel I completely filled	Σ	29b. Signature and title of certifier			29c. L	icense number	29d	. Date signed (Mont	h, Dey, Year)
,			MAIL				001421	2	06/07	2006
			1	completed cause of death (Item	n 23a) (Type,	Print)	1 Oi-	Λ	ste MI	2 1/421
				artascini	2001	Med	ical FKu	14. /tmap	101119	d'701
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State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2006 1/35 M 06 **Physician** Mayes ishae /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Neme (If not institution, give street and number) Examiner Anne 4nnapolis Arundel Medical Center Anne 9. Birthplace (State or Foreign Country), Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Min. **Funeral** Months Days Hours NIA 1 ☐ M 2 🕽 🕿 -07-2000 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State or 28a-f show and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show surnatic event, the Medical Examanar must be notified at 1 Nos 2 No Anne Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 103 !reek Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐ Yes 2 ☑ No f Yes, Give Year or Dates: lack Pages 1 and 2 should be filed within 72 hours after L□Mever Married 2 Married 1 Yes 2 00 Specify Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be lontora andon Layes Health and Mental)ary ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) dewater, Md 21037 53 Idle permit. Pages 1 and 2 Department of Health at Importent: If Itam 27 Is any injury or other trat Mayes Father 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 🖾 Other (Specify) in state 21. Signeture of Emeral Sovice Licensee Ronal Ld Sowade State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD nost Approximate Interval Between Onset and Death 23a. Part1. Enter the disease/or complications that caused the death shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition hour **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Po in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 → 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan 1 ☐ Yes 2 ☐ No 2 **W**No 1 ☐ Yes To the Hospital or Attending Physician: 26. Place of Death Check onl one 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Appatient 2 EP/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes 2 🗷 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death.

I Diractor: A
d in by the fu death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funaral D 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0014212 06/07/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Play. Annapolis, Md. 21401 Scartascini Kicardo 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 3 0 2006 State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 20647 State Registrar Amend ITEM#20a-c&22 PER FH C85 ptificate /of State 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year Physician Ronald K. Mills JUNE 21 2006 10:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Hospital St. Mary's Leonardtown Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Months 1**∑**M 2□ F Director 277-42-3145 60 June 4, 1946 Ohio Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow nia Hygiene. ad other than 'naturel', or items 23s or 28s-f ehov event, the Modical Examinar must be notitled at 1 Yes 2 No MD Director St. Mary's Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Cilizen of Whal Country? 29449 Charlotte Hall Road 20622 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I int: If Item 27 is marked of Leroy K. Mills Katherine Shyovich other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Misch/sister 5311 Naylor Street Painesville, OH Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 **XX**remation 3 ☐ Removal from State 4 ☐ Donation **SXPOL**her (Specify) in state ō = 6 permit. Page Depertment of Important: If any injury or once. 7/06/06 Metro Crematory Inc. Baltimore,Md 21. Signatu voi Funeral Service Licensee Rone Id S. Was 22. Name and Address of Facility Cremation Society Of MD.Inc. irector erry Baltimore, MD 2120121228 299Frederick Road 21 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** acute onset cardac 16 mm /Medical Due to (or as a consequence of): Examiner monam Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner or Attending Physicion: The law requires that the death certificate be executed anding physicien and use es the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE 23c. If yes, oulcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Be Completed by Yes 2□No 3 Probably 4 DUnknown W C 24a. Was an 24b. Were autopsy findings available pnor to completion of cause of death? autopsy performed? n'cotine! addiction MILLS of Vital 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of RONALD Division o Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural s after dec. 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funerel DI completely filled in 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the eause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR.KAE AUNG P.O. BOX37 HOLLYWOOD, MD. 20636 31. Date filed (Mgnth Pay Year) 2006 Registrar's Signature (mach) State Registrar

		-	For State	State of Marylan	d / Dep <i>Ce</i>	artment of F rtificate of	lealth ar <i>Death</i>		giene 2 () ()	6 20648
			Registrar 1. Decedent's Name (First, Middle, Last			-		2. Date of Dea		3. Time of Death
	Physicia /Medic		KATH LEEN	MAU	RER			04	33 300	
	Examin	er	4a. Fecility Name (If not institution, give	a	12	4b. City, Town, o		Death W M	4c. County of De	
-	Funeral		5. Social Security Number 6. S			If Under 1 Year	If Under 24	Hrs. 8 Date of Birt	h 9.8	irthplace (State or Foreign
	Director		11 1-40-1286	□M 2 F 58	Yrs.	Months Days	Hours	Min. (Month, Day	1948 Ne	w York
	land		Usuel Residence of Decedent 10a. State 10b. County	10c. City	, Town or L	ocation				10d. Inside City Limits
	Mary a-f eh	tor	MD]	Baltim	ore				1 √Yes 2 No
	or 28	Direc	10e. Street and Number	Q		10f. Zip Code	212	1	10g. Citizen of What	
	death with the Maryland ms 23a or 28a-f ehow	Funeral Director	6 Walden Cherry	12. Was Decedent Ever in U.	S 13	Was Decedent of H			USA 14. Bace - Ar	nerican Indian,
_	filed within 72 hours after death with the Marylan Hygiene. ther then - int, the Madical Examiner must be notified at	þ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	Black, W	
215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece (Give	edent's Usual Occup e kind of work done DO NOT use retired	ation during most o	of working	16b. Kind of Busines	ss/Industry
7		idmo	Elementary/Secondary (0-12)	College (1-4or 5+)		egistered			healthc	are
ם פ	be filed withing that Hygiene. Id other then event, the M	0	17. Father's Name (First, Middle, Last,			SISCERCE		s Name (First, Middle,		are
Jar		To B	Philip Joseph Fin	negan				Margaret Co		
Maryland	12 sho h and 7 le m		19a. Informant's Name/Relationship (Robert J. Maurer		4			or Rural Route Numbe ourt Baltin	•	, <i>Zip Code)</i> 21207
	Pages 1 and 2 should hent of Health and Mer int: If Item 27 le marke iry or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	lace of Disp	osition (Name of ematory or other place	- !	Date	20c. Location - City	
Baltimore,	permit. Pages Department of I Important: If Ite eny injury or of once.		4 ☑Donation 5 ☐ Other (Specification of European Service Libert S		S	Name and Addre Late Anat	ess of Facility Omy BO	ard 655 W.	Baltimore	Street
			23a. Part 1. Enter the disease, or com	plications that caused the deat		altimore, nter the mode of dyir		1201 ardiac or respiratory ar	rest,	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition		mia M	u a allem				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a Due to (or as a conseq	uence of): <) Direct ()				
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P.O. Box	at the death certific: by the attending plached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	□Ectopic pregnanc □ Other (specify) _	ý		23d. Date of o	delivery Day Year
rds, P.	quires that n signed b uld be deta	ρ	Part II. Other significant conditions of	contributing to death but not res	ulting in the	underlying cause giv	ven in Part I.			to the cause of death? Probably 4 Dunknown
Division of Vital Records,	To the Hospital or Attending Physicien: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed							rmed? prior t	autopsy findings available o completion of cause of ? es 2 \sum No
ita	clen: entifica ector, I	Be	25. Was case referred to medical examiner?	Hagnital		0		of Death (Check only o		
5	Physic this crat din	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 2 I	ER/Outpatie	SIII 3 DOA		sing Home 5 ☐ Resid	dence 6 Other (S	pecify)
0	nding Fith.: After a funer	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Injury	Wo	rk? Yes 2∐N		, , , , , , , , , , , , , , , , , , , ,	
Divis	al or Attended after death I Director:	Certification:	3 Suicide 6 Could not be determined		ome, farm, s	treet, factory, office		28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funerel completely filled	Medicai (nysician: To the best of my knominer: On the basis of examination and manner stated.						
	Within To the comp	×	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mo	enth, Day, Year)
			Raymond Mills				77683		6/21106	
			30. Name and address of person who Phymund Millir 2			e, Print)	rstown	MD 21136		
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	-Carr	U DOWN			
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DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

12:50 a.m.

2006

CHARLOTTE

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29,2006 **Physician** June ERNEST PERSHING PETERSON 9:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore 8218 Oakleigh Road Parkville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day Year 1 an . 1 a 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign .1919 **Funeral** 1**X** M 2□ F 213-05-0530 87 Yrs. Jan. Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hyglene. important: If item 27 is marked other then "natural; or iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Exercitive must be notified at once. MD Baltimore Parkville 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8218 Oakleigh Road 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done d life. DO NOT use retired) during most of working Manor Care-Ruxton Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Engineer 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ernest Eugene Peterson Susie Redmond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Denise Robinson-daughter 8218 Oakleigh Road-Parkville, MD 21234 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 7-3-06 1XXXurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cenetery Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 8800 Harford Road-Parkville, MD 21234 adole 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Izheimers **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit P.O. Box 68760, X Due to (or as a consequence of) attending physicien Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Day ó in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by should be 2 No 3 Probably 4 Unknown 1 ☐ Yes been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 1 ☐ Yes of Vital 24 hours efter death.

Funerel Director: After this certific letely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Magner of Feath 28b. Time of Division 5 Pending 1 Natural 1 Tes 2 No 2 Accident investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 To the ŝ 29d. Date signed (Month, Day, Year) 29b. Signature and title a certifier 29c. License number)4460Y nd address of person who completed cause of death (Item 23a) (Type, Print) 30. Name SLOSITMEFORD RY SUME E MICHAEL SUTER 31. Date filed (Month, Day, Year) State Registrar JUN 3 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9,10g,11,12,15,16asb,17,18, 19asb PerANA BD C880,6/02/08 JH State of Maryland 7 Department of Health and Mental Hygiene State Amend Items 25,27,28a-f per ME C8126a 66/29/06 dhb 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 7.65 **Physician** PETERSON 2006 MARY 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner (town A) COLUMBIH Howard CounTy GENERAL 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** 1911 Virginia 1 M 20 F 95 225-07-0174 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a. State the Medical Examiner trust be notified at 1 ☐ Yes 2 No CITY HU WARD ELLICUT Directo MU 10g. Citizen of What Country? 10f Zin Code 10e, Street and Number unk U.S.A. 21043 4309 College Avenue Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 out
If Yes, Give
Year or Dates: 11 Marital Status unk 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: white ģ 3 X Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker unk unk _12 . Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: if Itam 27 is marked other ti jury or other traumatic avant. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unk unk Julia Morehead Robert Walker Foard 19b. Majling Address (Street and Number or Rural Boute Number, City or Town, Stars, Zip Code) 4321 College Avenue Ellicott City, Md. 21043 5755 Gedar Lane Columbia, NP 21044 19a Informant's Name/Relationship (Type Print)
Julia P. Pallozzi/daughter
Howard Co. General Hospital Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: if any injury or once. Conald S. Wadas Sitestor 4 ADonation 5 ☐ Other (Specify) 21. Sanature of Fund Sarvice Ronal d 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRA TURY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): HT N Examiner MEDICAL EXAMINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ilTI ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 □ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð accordent 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes -200 Hospital: Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred
Fell while getting out of
chair 27. Manner of Death Date of Injury Certification: 01/04/2006 7:00 рм 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 X No investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

At house 28f. Location (Street and Number or Rural Route Number, 4321 College Ave., Ellicott 4 Homicide 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Discourse Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1 BOUR

Division of Vital Records, P.O.

Box 68760.

death with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore,

28a-f show

or items 23a or

"natural",

I Hygiene.

or Attanding Fo the Hospital

> State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
JUN 2 9 2006

30. Name and address of person who completed cause of death (Item 23a) (Type,

ORIGINAL

		1 - For Amend Items 2	State 29 Mary M	d GBeea Cer	06/29/66 tificate of	lealth and Death		iene 2001	5 20652
Dhuoisir		1. Decedent's Name (First, Middle, Last)	_		D		2. Date of Deal	th Day A Year	3. Time of Death
Physicia /Medic		Margaret	J.		Preston		HPCII	8,2006	540 gm
Examin	er	4a. Facility Name (If not institution, give sti	1 1/20	Total	4b. City, Town, o	or Location of De	The Let	4c. County of Dea	ın
		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast hirthday)	If Under 1 Year	If Under 24 H	Irs. 8. Date of Birth	9. Bir	hplace (State or Foreign
Funeral Director			M 2⊠F 71	Yrs.	Months Days		in. (Month, Day 5-9-3	, Year) Co	N.C.
		Usual Residence of Decedent						*	
nyland how		10a. State 10b. County	10c. City	, Town or Loc	cation				10d. Inside City Limits 1 XYes 2 □ No
e Ma	cto	Md. NA	Ba	altimo	re				
72 hours after death with the Maryland natural, or items 23a or 28a-f show deal Examiter mount be notified at	Director	10e. Street and Number	at Ant 3	D	10f. Zip Code 212	02	1	Og. Citizen of What Co USA	ountry?
ath w	rai	211 E. Lafayette					(Specify Vec or No.	14. Race - Ame	anican Indian
er de	Funerai	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No	S. 13. V	Yes, specify Cub	an, Mexican, Pu	(Specify Yes or No- ierto Rican, etc.)	Black, White	
irs afi	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Tyear or Dates:	1	☐ Yes 2X No	Specify:		Specify: B	lack
2 hou	ted	15. Decedent's Educa (Specify only highest grade	ation	16a. Deced	ent's Usual Occu	pation	working	16b. Kind of Business	/Industry
	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done OO NOT use retire	id)	HOIKING		
filed wil Hygien other th	Completed	llth grade		Hom	emaker		15: 14:14	Own Home)
d oth	Be	17. Father's Name (First, Middle, Last)	_				Name (First, Middle,	maiden Sumame) Burto	
parmit. Pages 1 end 2 should be filed within Department of Health and Mahall Hygiene. Important: If Item 27 is marked other then any Injury or other traumatic event, tha Mapping.	2	Eugene	Pres		a Address /Stree	Ida	Pural Poute Number	r, City or Town, State,	
12 st h and 7 is n traum		19a. Informant's Name/Relationship (Typ	_						
Healt Healt m 2		Clinton Clark 20a. Method of Disposition	Son 20b. P		sition (Name of natory or other pla		Baltimore, Date	20c. Location - City or	
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artme	9	21. Sonature of Funeral Service Licenses		-	. Name and Addr			imore, Md.	21202
permi Depa Impo		Hosert P	Walter	M	larch F.H	I. East	1101	E. North A	
		23a. Part . Enter the disease, or complic	ations that caused the deat	Do not ente	er the mode of dy	ing, such as card	diac or respiratory arr	rest,	Approximate Intervat Between
Physician		shock, or heart failure. List only one Immediate Cause (Final	cause on each line.						Onset and Death
/Medical		diselve or condition resulting in death)	Due to (or as a consequence	uence of):	/	/		11.1	
Examiner		b b	Sackal	Dec	ubit	us	1 /	MINER	
n =	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Lue to (or as a consequence	uence orj.			\ W\ /	ICAL	
acute ind trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	rarap 149	11U			APPROVED.		
yeician: The law requires thet the death certificate be executed is certificate has been signed by the attending physicien and director, page 2 should be detached for use as the burial-transit	Ä	resulting in death) Last	Thoracic sp		tenosis	SERT	FORTON APPROVE		
cate to chysic the b	dical	d.				Chi			
the Hospital or Attending Physician: The law requires their the death certification? A hours after death. The Funeral Director: After this certificate has been signed by the attending phyphelelly filled in by the funeral director, page 2 should be detached for use as the property of the funeral director, page 2.	Physician/Med	IF FEMALE: 23	sc. If yes, outcome of pregna	ancy				23d. Date of de	livery
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the graph of the g	ysi	1 ☐ Yes 2 ੴNo 9 ☐ Unknown	9□ Unknown						No. of Control of Cont
s thet	by P	Part II. Dther significant conditions conf	ributing to death-but not res	ulting in the u	nderlying cause g	iven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
quire n sign	pe pe	Monbra Obes	ity Dia	beter	3/1/21	1/itus	1 U Y	es 220 No 3 □ P	robably 4 Unknown
s been s shou	Diet		0,				24a. Was a autop	an 24b. Were a	utopsy findings available completion of cause of
The land te ha	Completed						perfor	med? death? 2 No 1 □ Ye	
refice stor, p	BeC	25. Was case referred to medicat				26. Place of I	Death (Check only or		
Physic Physic this ce	To	examiner?		ER/Outpatier	I SLI DOA		g Home 5 ☐ Resid	ence 6 Other (Spe	acify)
ng Phy fiter thi		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	We		28d. Describe h	ow injury occurred	
eath. or: A	ertification;	2 Accident investigation 3 Suicide 6 Could not be]Yes 2∐No	001 1 101		
or Att	E	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif.	ome, farm, str fy)	eet, factory, office	•	28f. Location (S City or Tow	Street and Number or R n, State)	fural Houte Number,
urs a urs a eral D	O	20a Cartifier 15 Cartifying Phys	ician: To the best of my kno	windan doot	n accurred at the	imo date and ni	lace, and due to the	causa(s) and manner a	e stated
Hosp 24 ho Fund Fund	edicai	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	er: On the basis of examina and manner stated.	ation and/or in	vestigation, in my	opinion, death o	occurred at the time, o	date and place, and du	e to the cause(s)
To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Med	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date signed (Mon	
F S F O					8	9510	0	4-14-	06
(1)		30. Name and address of person who co	impleted cause of death (Iter	n 23a) (Type,	Pript) /	100		1	10
0		Kyle Haym	e, m.D.	40 K	pRyll	and 6	reneral	X108P1	tall
	ate	31. Date filed (Month, Day, Yelac)	32. Pogistrar's Signa	ature				/	
Regist	rar	JUN 2 9 200	15 Batter	KA	and the				

James Edward Palmer

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

ines Edward		1- For State Registrar	Certificate of l		F	eg. IVO.	06 2065
Physici ledical Exam		1. Decedent's Name (First, Middle,Last) James E. Palmer			2. Date of Dea Month June 25,	Day Year	3. Time of Death 0247 hrs
		4a. Facility Name (if not institution, give street and number) 3528 Pine Cone Circle		City, Town, or Location		4c. County of Dea	th
Funeral			n yrs. last birthday)		nder 24Hrs. 8. Date of Bi	Charles rth(MM/DD/YYYY) 9. B	irthplace (State or
Director		218-90-7787 1AM 2F	32 _{Yrs.}	Months Days Ho	1.00		ountryWash.DC
any		Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Location	1			10d Inside City Limits
Maryland 28a-f show 1 at once.	tor	MD Charles	Edgewa	ter			1 Yes 2XXNo
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Menlal Hygiewith and "natural", or items 23a or 28a-f she rars in market other than "natural", or items 23a or 28a-f she mustic event, the Medical Examiner must be notified at once	Director	10e. Street and Number 3782 7th Avenue		10f. Zip Code 21037		Og. Citizen of What Cou	untry?
ath with tems 23 st be no	Funeral	11. Marital Status 12. Was Decedent Eve 13. Never Married 2 Married Armed Forces?	If Yes	Decedent of Hispanic (, specify Cuban, Mexic	Origin? (Specify Yes or No can, Puerto Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
after de: N", or i	by Fu	1 Yes 2X 3 Widowed 4 Divorced If Yes, Give Year		'es 2 X No spec	ify.	Specify: Wh	ite
hours ('natur Exami		15. Decedent's Education (Specify only highest grade complet Elementary/Secondary (0-12) College (1-4 or 5+)	ted) 16a. Decedent's during mos	Usual Occupation (Git of working life, DO N		16b. Kind of Business	
21215-0036 ould be filed within 72 1 Mental Hygiene s marked other than " ic event, the Medical.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th	Electr	rician		Chesape Electri	
21215-0036 uld be filed within 7 Mental Hygiene marked other than		17. Father's Name (First, Middle, Last) Gary Palmer Sr.			her's Name (First, Middle, tricia Pow	,	
212 hould be and Menta is mark	To Be	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing A		Number or Rural Route Num		e, Zip Code)
e, MD 2121 1 and 2 should be fi Health and Mental item 27 is marker r traumatic event.		Gary Palmer Jr. /brothe	20b. Place of Disposition		ad Baltimo	re MD 212	
Baltimore, MD permit Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat		1 X Burial 2 Cremation 3 Removal from State	spring H	r place) ill Memor	6/29/06	Hebron 1	
Saltir ermit F epartme nportai		4 Donation 5 Other Specify 21. Signeture of Funeral Service Licensee	22. Nar	ne and Address of Fac	ility 300 Mage	Ave Bal	to MD
Physician		23a. Part I. Enter the disease or complications that caused the		merry ru	ineral Home	e of Essex	× 21221 Approximate Interval
/Medical xaminer		Immediate Cause (Final disease a. Oxycodone int	•		, ,		Between Onset and Death
		or condition resulting in death) Due to (or as a conseque	ence of):				
	iner	if any, leading to immediate cause. Enter Underlying Cause	ence of):				
# 1 m	Examiner	(Disease or injury that initiated events resulting in death). Last Due to (or as a conseque	ence of):				2
760, cate be executed physician and he burial - transi	Medical I	d. X UNPENDED AMENDED	22° DIT 27 20°	ME . 050	0.0/0/05 777		
760, Icate be extended the burial of the bur		IF FEMALE: 23c. If yes, outcome of	23a,PII,27,28a of pregnancy		- 2	23d. Date of deliver	y
Division of Vital Records, P.O. Box 687 Hospital or Attending Physician: The law requires that the death certificate bours affore death Funeral Director: After this certificate has been signed by the attending lely filled in by the funeral director, page 2 should be detached for use as t	sician/	past 12 months?	a of do oth	death 3 Ector (Specify)	opic pregnancy	Month	Day Year
O. Bo t the deal by the all	Phys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but	t not resulting in the upo	dorlung goung gues in	Port 220 Did to	bacco use contribute to	
, P.O.	by	NArcotic and cocaine intoxicati		errying cause given in	1 Yes		
Vital Records, vysician: The law requir this certificate has been s director, page 2 should	Completed				24a. Was		utopsy findings available completion of cause of
tal Recorian: The la	Com				perfo 1 V Yes	med? death?	-
/ital rsician: nis certi	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient 3	Othor	th (Check only one) Nursing Home 5	Residence 6 🗸 Othe	r Coope
ing Phy After th	n: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Inju	ry 28c. Injury at Wo	ork? 28d Describe	now injury occurred	1. Ocene
Division tal or Attendir rs after death all Director: Aled in by the fu	catic	2 Accident Pending Investigation Fnd 6/25/20	006 Fnd 2:40 a		A UIK		
Division Hospital or Attend 24 hours after death Funeral Director:	Certification:	3 Suicide 6 X Could not be determined (Specify) House		ractory, office building,	or Town, S	Street and Number or Ru tate) 3528 Pine MD	Cone Circle
he Hospital in 24 hours he Funeral pletely filled		29a. Certifier 1 Certifying Physician: To the best of my knowne) 2 Medical Examiner: On the basis of examinat	owledge, death occurred	d at the time, date and	place, and due to the caus	e(s) and manner as star	ted.
To the within To the complet	Medical	and manner stated 29b. Signature and title of certifier		29c. License numb		29d. Date signed (Mo	
		Mayrie Meybule		O.C.M.E.		June 25, 2006	
		30 Name and address of person who completed cause of death Margarita Korell MD. Assistant Medical Exa	,	in Street, Baltimo	ore, MD 21201		
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Si				_	
Regis	trar	UN 3 0 2006 Blown	per personal				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:50 AM M June 28, 2006 Ardella Payne /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11/19/1919 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 V 86 220-14-8078 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if them 27 le marked other then "natural", or theme 23e or 28e-f ehow emy injury or other treumatic event, if a Madical Examination in the coefficial at once. 1 Hes 2 No MD Baltimore City Baltimore Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2814 Virginia Avenue Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black à 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Family Homes Elementary/Secondary (0-12) College (1-4or 5+) Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Nealy Unknown Sam Payne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Novella Gibson/Daughter 251-1 Ladies Mile Road Richmond, VA 23222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jun 30 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland 2006 Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) dder CAVCINOMA Physician /Medical Due to (or as a consequence of) Examiner Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sicien and burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical The state of IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed2 2 No 1 ☐ Yes 2 🗖 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HO 3 p1 Ce Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this After this funeral of 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 29,2006 no who completed cause of the (Item 23a) (Type, Print) N. Charles St. Balto, and 21205

DHMH 17 Rev 1/2001

Registrar

Riley

31. Date filed (Month, Day,

BMG

6701

32. Redistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤈 0655 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician Iris Zennia Pendry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Heauth Hurner Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Hours Months Days 1 □ M 2 □ 162-26-4720 80 April 6, 1926 | Virginia Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygelns and antal Hygelns and and a fracted other then "natural", or items 23s or 28s-1 show and it items 7 is marked other then "natural", or items 23s or 28s-1 show ury or other traumatic event. The Medical Examinar must be rightlind at ury or other traumatic event. 1 ☐ Yes 2 No Maryland Director Harford Street 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 21154 USA Funeral 2953 Dublin Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Se condary (0-12) College (1-4or 5+) Line Worker <u>Shoe Manufacturer</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucy Belle Henderson Barnett Calvin Pendry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2952 Dublin Road, Street, Maryland 21154 Freda M. Dunivant/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 Removal from State permit. Page Depertment of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Forest Lawn Cemetery 6-30-06 Glendale, California 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Rd. Abingdon, MD 21009 (ussell Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician A O Demen /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner cate has been signed by the attending physicien and spage 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknows 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MIN autopsy performed? After this certificate has 1 Yes 2 No 2/2 No 1 ☐ Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Be Hospital: Other: 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1. Natural 5 Pending investigation 1 Yes 2 No death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M.D. D56545 126/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHILP) KHOSLA 200 HAYS ST #102, SEL AIR 32. Raistrar's Signature 31. Date filed (Month, Day, Year) UN 3 0 2006 State Registrar

			1 - For State Registrar	usc			and / Depa		t of H	ealth a	and M	_		e200		20656
			Decedent's Name (First, Mid	dle, Lasi	t)							2. Date of D	eath			3. Time of Death
	Physicia	an										Month		2006 Yea	ar	1:50 PM
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	Funeral		5. Social Security Number 218–76–2394	6. Se	x ⊐M.2M∑F	7. Age (In	yrs. last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D	ay, Yea	(r) 9. 1		ce (State or Foreign y)
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			For State Registrar	State of	of Maryland	Depa Cer	artment of He tificate of E	ealth and M Death		ene 2 ()	06	2065
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	Examir		4a. Facility Name (If not institution, gi		umber)		4b. City, Town, or			4c. County		
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	Funeral Director		,	50x 1∏M 2□F	7. Age (in yrs. last	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,) Dec 11,	(ear)	9. Bittil Coul Mary	olece (State or Foreign ntry)
			Usual Residence of Decedent						Dec 11,	1723	nary	<u> </u>
	ylanch how		10a. State 10b. County		10c. City, T	own or La	cation				1	10d. Inside City Limits
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is sny injury or other tra <u>once</u> .		21. Sign ture of Funeral Service Lice		irector	St	Name and Address	of Facility my Board MD 2120	655 W. H	Baltimo	ore S	Street
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	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death	h	4c. County of Death	
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*	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In ves. last birthday) If Under 1 Year If Under 24 Hrs. 7. Age (In ves. last birthday) Months Days Hours Min.	8. Date of Birth (Month, Day, March	Year) Coul	place (State or Foreign http:// Lawlina
	yland now		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1	Od. Inside City Limits
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Vital	Physician: The this certificate ral director, pag	Be (examiner? . A	ath Check only one	8.	
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Division	Attend r death ector: by the	Certification:	Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town	reet and Number or Rur , State)	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I		29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.			
	thin 24 o the Fu	Medical	29b. Signature and title of certifier 29c. License number		9d. Date signed (Month,	, ,
	⊢ ≯ ⊢ ŏ		Much ND DOC5180	17	6/26/0	φ
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Type)	Doel	At also	421042
	St Regist	ate rar	31. Date filed (Month, Day, Year) 2. Registrar's Signature		7	•

			For State Registrar	State o	f Maryland		artment tificate				Re	g. No.	200	6 2	0659
	Physicia	an l	1. Decedent's Name (First, Middle,								2. Date of Deat Month JUNE	Day 28	2006		e of Death 20A M
	/Medic	al	JANICE E. RENNI 4a. Facility Name (If not institution, g		m <i>her</i> }		4h City	Town or	Location o	f Death	JUNE		ounty of Dea		ZUA ™
	Examin	er	GILCHRIST CENT		11001)		10. 0.0,		NSON				BALTIM		
	Funeral			. Sex	7. Age (In yrs. la	ast birthday)	If Under Months		If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day JUNE 2/				te or Foreign
	Director		216-66-8965	1□ M 2 / √F	69	Yrs.	- INIONIANA	Cuys	110515		June 27	, 193	37 M	arýlar	nd
	land bw	}	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Insid	e City Limits
	Mary I sh	ţ	Maryland Baltime	ore City		Ba]	Ltimor	re Ca	ity					1 🗷 '	Yes 2□No
	or 28s	lirec	10e. Street and Number				10f. Zip				11	-	on of What C	ountry?	
	ath wi	rai	3127 Woodhome						234			US			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show appring yor other traumatic event, Ite Medical Examinar mout be notified at anone.	by Funeral Director	11. Marital Status Y Never Married 2 Married 3 Widowed 4 Divorced	Armed Fo	≱ (XNo ve	i	Was Deced If Yes, spec 1 □ Yes 2		spanic Orion, Mexican Specify:	gin? (Spec , Puerto R	cify Yes or No- lican, etc.)		Black, Wh	erican India ite, etc. White	٦,
S O	72 ho	eted	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	dent's Usua kind of wor DO NOT us	i Occupa k done d	ation Juring most	of working	g	16b. Kind	d of Busines	s/Industry	
2	vithin ne. han "	Completed	Elementary/Secondary (0-12)	College (N/A	1-4or 5+)		<i>po not us</i> erk	e retired,)			Ret	tail		
0 0	filed v Hygie other t		12 yrs. 17. Father's Name (First, Middle, La			010			18. Mothe	r's Name	(First, Middle, A				
<u>a</u>	should be t and Mental I s marked or umatic eve	To Be	John P. Renner						Eliz	abeth	n Dippel	L			
2	and 2 sho ealth and h n 27 is me		19a. Informant's Name/Relationship Shirley R. Spi			9925	Bird	Riv	er Rd		Route Number, Ltimore				20
Baltimore,	Pages 1 and nent of He and to the and to the and the a		20a. Method of Disposition XXBurial 2 Cremation 3 4 Donation 5 Other (Spe		State	lace of Dispo emetery, crer ckwood			1	7-1-2			imore,	r Town, Stat Md .	9
Balt	permit. Page Department Important: fi any injury or once.		21. Signature of Funeral Service Li			22	Lassa Lassa 7401	d Addres ahn Bel:	s of Facilit Funer air R	al Ho d. Ba	ome altimore	e, Mo	d. 212	36	
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that only one cause on o	caused the death each line.							est,			mate Between and Death
2	Physician		Immediate Cause (Final disease or condition resulting in death)	a	DAN		ati	C	CA	nci	eR				ean
	/Medical Examiner		Toodking in docum,	Due to	(or as a consequ	vence of):								0	
	2	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to	(or as a consequ	aence ol).									
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	c											
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687	physics the t	dicai		d								-			
P.O. Box (Physician: The law requires that the death certificat this certificate has been signed by the attending phyral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live I	tcome of pregna birth 2 Fetal nant at time of de lown	death 3	⊒Ectopic pro ☐ Other (sp			2001		23	d. Date of do Month	elivery Day	Year
σ.	that the poly of t	y Ph	Part II. Other significant condition	s contributing to d	eath but not resu	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did tob	acco use	contribute	to the cause	of death?
rds	w requires been sign should be										1 □ Ye	s 2 🗹	No 3□F	robably 4	□Unknown
Vital Records,	The law requate has been page 2 should	Completed									24a. Was a autops perform	y ned?	24b. Were a prior to death?	completion	ngs available of cause of
/ita	iclan: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital: 4 G				Otho	· ·		(Check only on	-	_	7	f
Division of 1	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date (Mor	Inpatient 2 1 of Injury oth, Day Year)	ER/Outpatier 28b. Time of Injury		8c. Injury Work	4 LINU	2	ie 5 ☐ Reside 8d. Describe ho			ecify)	ospice
Divis	tal or Attars after de al Directo	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200 Place	e of Injury - At ho ling, etc. <i>(Specif</i> y	ome, farm, str	reet, factory	r, office		2	8f. Location (St. City or Town	reet and , State)	Number or F	Rural Route	Number,
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	edicai	(Check only 2 Medical E	Physician: To the xaminer: On the band man	e best of my know pasis of examinat nner stated.	wledge, deat tion and/or in	vestigation,	, in my op	oinion, dea	d place, at th occurre	d at the time, da	ate and p	lace, and du	e to the cau	
	To the within Comple	Σ	29b. Signature and title of certifier	Trung 16	lily.	up			number	05				8,2(
	6		30. Name and address of person w	46B1	nc 6	23a) (Type,	Print)	Rus	les S	7. 1	Balto	. W	14 2	120	۶
	Sta Regist		31. Date filed (Month, Day, Year) JUN 3 0 20	A.27	Registrar's Signa	Ace	200								
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle, Last) Month Day 2006 **Physician** June 24, 6:01 P RICE VIRGINIA ELMA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Somerset Crisfield 26771 Johnson Creek Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 1) | August 12, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months 1 M 2 X F Yrs. 76 Maryland Director 214-26-5991 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location rthan "natural", or itams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🛮 No Funeral Director Crisfield Somerset Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21817 26771 Johnson Creek Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be it of Health and Mental Virginia Lampley ပ Charles Collars 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21817 David Macneal (Son) 26875 Johnson Creek Road -Crisfield, Maryland 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: if its
any injury or ot
once. cemetery, crematory or other place 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Cardens June 29, 2006 Hebron, Maryland 21. Signature of Funeral Service Liegnsee

Mary Beth Bradshaw-Pruitt 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, Maryland 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 45CV D Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, hand, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be axecuted burial-transit Due to (or as a consequence of) Box 68760. attending physician Physiclan/Medlcal the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 XNo 9 ☐ Unknown Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 2 No 1 Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 esidence 6 Other (Specify)
Injury at 28d. Describe how injury occurred Hospital: 1 Yes 2 ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? 28b. Time of Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time. 29a. Certifier Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-48098 0 June 26, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, Maryland 21817 31. Date filed (Month, Day, Year) 327 Registrar's Signature State JUN 3 0 2006 Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	C	ertificate d	of Death		Re	g. No.	105 2066
Physical Exar		r Jazmin		J.		inson	2. Date of Deal Month June 24, 2	Day Year 2006	3. Time of Death 0525 hrs
Micohen.		4a Facility Name (if not institution, give 5702 Eagle Street	street and number)		4b. City, Town, Capital He	or Location of Dea eights	ath	4c. County of Prince Ge	
Funera Directo		5. Social Security Number 6. Sex 157–66–7580 1X	7. Age (In yr	rs. last birthday)			1in	th(MM/DD/YYYY) 5-1977	9. Birthplace (State or Foreign Country) N.J.
i low any	ū .	Usual Residence of Decedent 10a. State 10b. County N.J. NA	10c. C	City, Town or Loca					10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number		TITIGE	10f. Zip Code		10	Og. Citizen of What	
th the N					0703			USA	
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f She	by Funeral		12. Was Decedent Ever in Armed Forces? 1 Yes 2 No of Yes, Give Year or Dates:	lf.		an, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14. Race White, o	
hours a			y highest grade completed	1) 16a. Decede during		pation (Give kind of fe. DO NOT use n		16b. Kind of Busin	ness/Industry
036 thin 72 ne.	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4 or 5+)	Se]	Lf-Emplo	yed		R&R Tow	n Car Service
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Cor	Howard	R	obinson		Jo	me (First, Middle, N YCE	Ва	ker
ore, MD 21215-00. set and 2 should be filed with of Health and Mental Hygiene If item 27 is marked other ti	To Be Co	Edith Parker	Sister	1 11	1726 S.	Laurel D	r. Apt.]	ber, City or Town, L-c, Laur	el, Md. 20708
Page Page	5 I	20a. Method of Disposition 1	Removal from State	ob. Place of Dispo crematory or c Gracelar	other place)	Pk. 6	Date -30-06		rth, N.J.
Balti permit. Departn Imports		7, ,	one			.H. East	1101	E. Nort	Md. 21202 h Ave.
Physicia /Medica	ıl _{an}	23a Part I. Enter the disease, or complifailure. List only one cause on each Immediate Cause (Final disease a. N	cations that caused the dea h line. Multiple Gunshot Wo		the mode of dyin	g, such as cardiad	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
xamine	er	Part 111 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ue to (or as a consequence						
	je L	Sequentially list conditions, b. if any, leading to immediate	ue to (or as a consequence	e of):					
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ficate be executed gphysician and			AMENIDED				· · · · · · · · · · · · · · · · · · ·		
8760, ifficate be e	/Medical	IF FEMALE:	AMENDED 23c. If yes, outcome of pr	regnancy				23d. Date of de	livery
	ian/l	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of	2 F		Ectopic preg	nancy	Month	Day Year
Box 687 he death certific	Physician	1 Yes 2 No 9 Unknown	9 Unknown		Other (Specify)				
P.O.	3 11		ontributing to death but no	ot resulting in the	underlying cause	given in Part I.			te to the cause of death? Probably 4 Unknown
ords, P.C w requires that is been signed t	Completed						- 24a. Was a	n 24b. We	re autopsy findings available
of Vital Records, g Physician: The law requir	î 2						autops perform 1 ✓ Yes 2	m <u>ed</u> ? dea	r to completion of cause of th? Yes 2 No
tal Rection: The certificate	o Be Con	25. Was case referred to medical		<u> </u>	26.Pla	ce of Death (Chec			7 100 2 10
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Sion of Attending Pl r death rector: After	ution: T	1 Natural 5 Pending	Jun 24, 2006	0430 hrs		Yes 2 V No	Subject shot		
. ≥ p ag id :	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e Place of Injury - A	at home, farm, stre	eet, factory, office	building, etc.	or Town, St	treet and Number of ate) St, Capital Hei	or Rural Route Number, City
D To the Hospital within 24 hours To the Funeral		(Check only 1 Certifying Physicia	n: To the best of my knowl On the basis of examination and manner stated				nd due to the cause	e(s) and manner as	started.
# \$ F \$ F \$	Medi	29b/Signature and title of certifier				nse number			(Month, Day, Year)
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H	6	3 Name an address of person who con Laron Locke MD. Assista	ompleted cause of death (It ont Medical Examine		n Street, Balt	imore, MD 21	201		
	State istra	7.1.187 57 73 77111	32. Registrar's Sign	nature	ente				

06-04364 Michele Reves

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar			Cer	tificate o	f Deat	h			Re	g No.	4	JUC	2000
Physicia	n/	1. Decedent's Name (First, Mid	dle,Last)							М	ate of Deat	Day	Year	3.	Time of Death
edical Examii		Michele			eanet	te	45 03: 1	Rea			ine 22, 2	006	ounty of I	Doeth	0448 hrs
- 14		4a. Facility Name (if not institut University of Marylan)		4b. City, 1		ocation of De	eatn		4c. C	ounty of i	Jeam	
Funeral	4	Social Security Number	6. Sex		je (In yrs. la	ıst birthday)		er 1 Year	If Under 24	4Hrs. 8.	Date of Birt	h(MM/DE)/YYYY)	9 Birthp	lace (State or
Director			1 M	2V F	41	Yr	Month	s Days	Hours	Min.	06 2	3	64	oreign Count	ry) MD
	}	220-86-1688 Usual Residence of Decedent		~\A_'	41						20 2	. 5	04		MD
any	ı	10a State 10b, County	,		10c. City,	Town or Loca	tion							- 1	Od Inside City Limits
and show nce.	5	MD N	IA		Ва	ltimo	re							1	X Yes 2 No
Aaryla 28a-f 1 at o	ect	10e. Street and Number					10f. Zip	Code			10	Og. Citizer	n of What	Country	?
ith the Maryland 23a or 28a-f show any notified at once.	ā	612 Reservoi	r St	ceet				2121					U.S.	Α.	
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ore, MD 21215-003 and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other the her traumatic event, the Med	ŀ	Juanita Boyd 20a. Method of Disposition	-Moth	.er		Place of Dispo	sition (Nar	ne of ceme		Dat		20c. Lo	cation - C	ity or To	wn, State
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Balt permit. Depart Impori	1	KI MAANIA	/[]	tru	nit	M	arch	F/H Waba	Wes	t ve.	Balt	imo	re,	Md	21215
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(4	r condition resulting in death)	Due t	o (or as a cons	sequence of	f):									
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Box 687 c death certific the attending of	Physicia	1 Yes 2 No 9 🗸 U	nknown 9		at time of de	ath 5 C	other (Spe	cify)				4			
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Division of Vital Records, rat or Attending Physician: The law required attendenth. In Director, After this certificate has been sided in by the funeral director, page 2 should be	Certification:	3 🗸 Suicide 6 Co	uld not be	28e. Place of I			eet, factory	y, office bu	ilding, etc.		or Town, S	tate)			Route Number, City
Di spital hours a neral I	Çe	4 Homicide	termined	(Specify) M						10.8	East No				
Division of Vital Records, P.O. Box 68 to the Hospital or Attending Physician: The law requires that the death certiments after detendent. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying one) 2 Medical E	Physician: caminer:On	To the best of r the basis of ex	ny knowled amination a	ge, death occ ind/or investig	urred at the ation, in m	e time, date y opinion,	e and place, death occur	, and due red at the	to the caus time, date	e(s) and a	manner a e, and due	s started e to the c	ause(s)
To t With To t	Medical	29b Signature and title of cert	and	manner stated	<u>.</u>			c. License							, Day, Year)
			11/	1/				O.C.M					23, 200		·
		30. Name and address of pers	on who come	leted cause of	death (Item	1 23a)						L			
3				ef Medical E			enn Stre	et, Balti	more, ME	D 2120	1				
	tate	31. Date filed (Month) Pak Yes	7) 0 200	32. Redistr	ar's Signati	Jr.e	1-								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item I per doc 2856 6-30-06 vt.

State of Maryland Department of Health and Mental Hygiene () ()

1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Tamara Jean Rutherford Month 1. Decedent's Name (First, Middle, Last) MA IIGO Physician 23 2006 /Medical 4c. County of Death Baltumore City 4b. City, Town, or Location of Death Baltumore 4a. Facility Name (If not institution, give street and number) Examiner JHBM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June 23, 2006 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 ☐ M 2 🖫 F n/a Maryland n/a Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madrial Examinat must be rodified at once. 10b. County 10a. State 1 ☐ Yes 2 🛛 No Baltimore Dundalk Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 USA 1908 Inverton Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1√2 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) n/a Elementary/Secondary (0-12) n/a n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dana Emanuel Brian Rutherford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Donna Bolton-Grandmother 1908 Inverton Road Dundalk, Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2XXX remation 3 ☐ Removal from State Bayview Crematory 6-28-06 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Ave. Baltimore, Md. 21222 Polis 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death prematurit Immediate Cause (Final disease or condition resulting in death) extreme one hour Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicien and fiely filled in by the funeral director, page 2 should be detached for use as the bunat-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \(\square\) No 1 X Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; Injury 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide To the Hospitel within 24 hours a To the Funeral C 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier gans knu3W 30. Name and address of person who completed cause of death (Item 23a (Type, Print) Roxanne Jamishidi, M.D. 4940 Eastern Ave. Baltimore, Md. 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JUN 3 0 2006

CHEAT!

Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. Street and Number 10c. Street and Number 10c. City, Town or Location 10d. Street and Number 10d. Street and Number 10d. Citizen of What County 10d. Citizen of What County	thplace (State or Foreign punty) 10d. Inside City Limits 1 Wes 2 No
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हिं पुंची के 3 ि Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 □ No Specify: Speci	hite
3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business	/industry
Specify: Windowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify:	g Contractor
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17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Address (Street and Number or Rural Route Number)	Zip Code) 2/237
Don Noudan 9201 Nottingwood Rd. Rosedd 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or	c, mo
O 8° = 5 1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State	lmm
4 Donation 5 Other (Specify) 1 To a light of the state o	chape 1 /
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_ gual	s stated.
The second of th	
Shalini Kana MJ 139788 6/29	106
30. Name and address, of person who completed cause of death (Item 23a) (Type, Print) Shalipi Kama MD, 9512 N. Hartord Rd. MD =	7234
State 31. Date filed (Month, Day, Year) 32. Pigistrar's Signature Registrar 111N 3 0 2006	

		1	For State Registrar	State	of Marylai		rtment of H			ene 2	006	20665
	- J		Decedent's Name (First, Middle,	Last)					2. Date of Death		Year	3. Time of Death
Y a	Physicia /Medic		James Edward S	kinner, Jr	•				Month 06	^D 27	2006	950AM
	Examin		4a. Facility Name (If not institution,	-	ımber)			Location of Death		4c. Co	unty of Death	
			Johns Hopkins		7 000 (10 110	. last birthday)	Balti If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	L	9 Birthn	lace (State or Foreign
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	yland		10a. State 10b. County		10c. C	ity, Town or Lo	cation				11	Od. Inside City Limits
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	filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or ttema 23a or 28a-f ehow ent, the Medical Exeminar must be poutfled at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 🔀 Marrie	Armed F	orces?	0.3.	f Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)		Black, White,	
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and	I be fi	Be	JAMES E.SKINNER,						WILLIAMS		,	
Ë	should be nd Mental marked umatic ev	T	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number,	City or T	own, State, Zip	Code)
Z	d 2 th a		Elizabeth Brown			2110	Braddish A	ve. Baltim	ore.MD 212	16		
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other	Ì	20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place		The state of the s		tion - City or To	wn, State
E	Page lent o nt: If ry or		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp			•	orest Vet.		3/2006	wines	Mill, N)
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,	121		30. Name and address of person	who completed ca	use of death (I	tem 23a) (Type	Print) Johns	1topkin, 1	to sp. tal	14	•	
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		-	For State Registrar	State of Marylan		tment of F			giene 2	006	2066	5
			Decedent's Name (First, Middle, Last)		0 1	1		2. Date of De		Year	3. Time of Death	
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	Examin	_	4a. Facility Name (If not institution, give s	Ω . \sim \sim		4b. City, Town, o	r Location of Death			unty of Death	Himam G	
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	r 28a-	rect	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?	_
	within 72 hours after death with the Maryland ene. then 'natural', or items 23e or 28e-f ehow in Medical Examiner must be notified at	Funeral Director	7408 Brightsid	e Avenue		21237			USA			
	tems	uner		Was Decedent Ever in U. Armed Forces?	S. 13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14.	Race - Americ Black, White,		
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ██No If Yes, Give Year or Dates:	11	☐Yes 2X No	Specify:		Sp	ecity: Whi	.te	
Š	'2 hou	ted	15. Decedent's Educ (Specify only highest grade	cation	16a. Decede	nt's Usual Occup	pation	rkina	16b. Kind	of Business/In	dustry	_
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	Hygier Hygier Ther ti		10th 17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle	, Maiden Sui	mame)		
lanc	id be fental liked o	To Be	Andrew G. Sta	ab				S. Wagn				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show says injury or other treumatic event, the Medical Examiner must be notified at ADGS.		19a. Informant's Name/Relationship (Type			·	and Number or Ru					
	1 and Health em 27 thar t		Elsie Staab / w	20b. P	lace of Dispos	tion (Name of	side Av	Date Date		ion - City or To		-
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Вох	eath certific attending pl for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3 □	Ectopic pregnancy Other (specify) _	y		23d	. Date of delive Month	ery Day Year	
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brd	v require been sig should b		Atrial +19	PLINATION				10	Yes 2□N	lo 3 🗌 Prol	pably 4 0 0 nknown	
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Division	i i i i i	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, rarm, stre y)	et, factory, office		City or To	wn, State)	umber or Hun	al Route Number,	
	To the Hospital or Attent within 24 hours effer death To the Funeral Director: completely filled in by the	edical C		sician: To the best of my kno ner: On the basis of examina and manner stated.								
	To th To th comp	Me	29b. Signature and title of certifier	18 11		29c. Licens	se number		29d. Date s	igned (Month,	Day, Year)	
	ſ		MUMY	UN MEDICA	LOUTU	2 14	3-000		JUNE	- 27	2006	
	6		30. Name and address of person who co	mpleted cause of death (Item	ERN A	VENJE	BATIMO	RE MA	RVIA	NO 2	1221	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	Besiel.	60			1011	у		
	Regist	rar	0014 0 0 5000	A Company of the	State of the State	alle see						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 12:45 M SEVERN 28 KENNETH SUNS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE C If Under 1 Year If Under 24 Hrs. Baltimore City CITY HE ZOHWS
Social Security Number HOPKINS HOSPITAL Date of Birth (Month, Day, Year) Nov. 11,1928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Maryland **Funeral** Months Days Hours 1**X** M 2□ F Min 77 Director 217-24-7460 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State rthan "natural", or items 23a or 28a-1 shov the Nedical Examinar must be notified at 1 XYes 2 □ No Baltimore City Maryland Baltimore City Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 USA 1651 E. Belvedere Ave. 12. Was Decedent Ever in U.S. Armed Forces?

X X Yes 2 JNO 14 Yes, Give Korean Year or Dates Conflict. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by XX Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) it Hygiene. Elementary/Secondary (0-12) 8 yrs. College (1-4or 5+) Self~Employed Painter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fill thent of Health and Mental H tant: if Item 27 is marked off jury or other traumatic even Annie Smith August Severn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 67 Beaver Ct. Rising Sun. Md. 21911 Betty Rykiel (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page Department of Important: if any injury or once. XX Burial 2 Cremation 3 Removal from State 7-1-2006 Woodlawn Cemetery Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Mensee Lassann Funeral Home 63 assahn 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of) Examiner Infection me Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or a consequence of): Stenosi Aortic Physician/Medical attending I 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the aid be detached for 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signated to page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed; this certificate 1 Yes 21 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 Nopatient 2 ER/Outpatient 3 DOA 2 To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Wann, MEDICAL DOCTOR RES-000 June, 28, 2006 Iracy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE TRACY WANNER THE TOHMS HOPKING HOSPITAL, GOD NORTH WOLFE STREET,
31. Date filed (Month, Day, Year) 32. Registrar's Signature MD State Registrar JUN 3 G 2006

			For State Registrar	te of Maryland		artment of H			giene 20	06 20668
	Dhusisi		1. Decedent's Name (First, Middle, Last)	C ()			.	2. Date of Dea	ath	3. Time of Death
	Physici /Medio		Altred L.	Stoke.	ک			JUNE 0	24 200	6 10:40 AM
	Examir	er	4a. Facility Name (If not institution, give street a Sinai Hospital of	Baltimose		Ballimse	r Location of Death		4c. County of	Death N/4
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 2	7. Age (In vrs. la	st birthday) 7 Yrs.	If Under 1 Year Months Days	If Unday 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	y, Year) 9,1938	Birthplace (State or Foreign Country)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	ecation				10d. Inside City Limits
	h the Marylan r 28a-f show	tor	MD N/A	B	eltomo	ne				1 ☐Yes 2 ☐ No
	death with the Maryland ms 23a or 28a-f show (must be nuttled at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	,
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-	ъ ≗ ≅	by Fun	1 Never Married 2 Married 1	ned Forces? Les 2 ☐ No		f Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, Specify:	White, etc.
3 8	2 hour	ed b	15. Decedent's Education	ar or Dates: 1745	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busin	ness/Industry
PRES	thin 72	Completed	(Specify only highest grade comp	leted)	(Give life.	DO NOT use retired	,	ing	_	,
H	iled wi dygien ther th	S	17. Father's Name (First, Middle, Last)			Techn		o /First Middle	Boll Maiden Sumame)	Atlantic
STOKES, ALFRED	ie, wall yialia Z IZ IS-005 s 1 and 2 should be filed within 72 hours Fleath and Mental Hygiene. Item 27 is marked other than "nature".	To Be	441	kes					skkes	
TOKES	2 should and Meni le marke		19a. Informant's Name/Relationship (Type, Pri	Si .			and Number or Run			
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0,	Dalifillion permit. Pages Department of important; if is sny injury or o		21. Signature of Funeral Service Licensee	_	22	Name and Addres	ss of Facility	Dr. 1 5	enita	P.A.
9						5126 Be	lain to an	BUH	nove mo	P. A. 21286-5105
			23a. Part1. Enter the Visease, or complications shock, or heart failure. List only one caus Immediate Cause (Final	s that ceused the death. se on each line.	Do not ent	- (or respiratory ari	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Oue to (or as a conseque	nce of):	CANCE			 	1 days
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	that the de	hys	9 □Unknown	Unknown						
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year O a change a lesiV so majori ile	Attending Physicien: The law requires that the death certificate be executed cash. To add the cash certificate be executed cash. As actor: After this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	Completed by							an 24b. Wei	re autopsy findings available or to comptetion of cause of th?
	ician: sertifica ector,	Be	25. Was case referred to medical examiner?	,		l ou	26. Place of Death			
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	To the Hospitel or Attency within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: Or an	To the best of my knowled the basis of examination displayments and manner stated.	edge, death on and/or inv	occurred at the time vestigation, in my op	ne, date and place, principle, death occurrence.	and due to the c ed at the time, o	ause(s) and manne late and place, and	er as stated. I due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		M D	29c. License	a number	2	29d. Date signed (A	Month, Day, Year)
	7		Marish 260		1	KES	-000	J	TUNE 21	192006
	10		30. Name and address of person who complete	d cause of death (Item 2 A Registrar's Signatu	West	Belveder	e Avenu	e, Balti	more M	10 21215
	Sta Registr		31. Date filed (Month, Day, Year) JUN 3 0 2006	32 Registrar's Signatu	re Ace	de				

			1 - For Stata Registrar	State of Maryla	•		of Health an		giene Rag. No.2006	20669
	Physici	an	Decedent's Name (First, Middle, La	_				2. Date of De Month		3. Time of Death
	Physici /Medi		Kathleen	SAVAGE	<u></u>			JUN &		
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			Johns Hopkins 5. Social Security Number 6.5		. last birthday)				th 9 Bir	tholace (State or Foreign
	Funeral Director			1 M 202 F 5				Vin. Janua Janua	V. Year)	thplace (State or Foreign ountry)
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	yland		10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits
	Ma-f	ctol	MD N/K	- 1	Sultimo	ne				1 Types 2 □ No
	iff th	Funeral Director	10e. Street and Number			10f. Zip Co	de		10g. Citizen of What C	ountry?
	ath w	rai		enve - Apt-S	5		21217			dan lada
	er de	une	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ Xo	0.5. 13.	If Yes, specify	Cuban, Mexican, P	? (Specify Yes or No Juerto Rican, etc.)	14. Race - Am Black, Whi	
36	rs aft	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐	No Specify:		Specify:	American
5-0036	72 hours after death with the Maryland naturel', or fleme 23a or 28a-1 ehow dittal Examiner must be multified at	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual O	ccupation		16b. Kind of Business	/Industry
215	within 7; iene. then "n	ple	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use n	one during most of etired)	working		
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Maryland	and ie n		19a. Informant's Name elationship		1				er, City or Town, State,	1
-	1 end Health em 27 ther tr		20a, Method of Disposition	20b.	Place of Dispo	osition (Name o	rk Aven	Date	20c. Location - City or	
Baltimore	nt of nt of nt of no o		1 Burial 2 Cremation 3	Removal from State	cemetery, cre-	matory or other	r place)	- 22-N	10 av 10 av	
臣	permit. Pages Department of Important: If i any njury or ones.		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service) Lice	1. 1	guien	2. Name and A	ddrass Facility	-27-0	Sultimon	200
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А	Physician /Medical		disease or condition resulting in death)	a. Multiongo Due to (or as a conse	ZV - VX	rem T	dillie			2 weeks
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9	a Se E	Me	IF FEMALE:	23a If you system of progr	2004					
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 mopths?	23c. If yes, outcome of pregr	aldeath 3	Ectopic pregn			23d. Date of de Month	livery Day Year
		ysic	1 ☐ Yes 2 1 No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5L	Other (specif	y)			
P.0	law requires that the death cer es been signed by the attendir 2 should be detached for use		Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying caus	e given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
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Vital	ifficat or, pa	ပိ	25. Was case referred to medical				26 Place of	1 ☐ Yes Death (Check only of	2 ☐ Yes	2 1 10
i	Physiclen: this certificatal director, I	To B	examiner? 1 res 2 No	Hospital: 1 Thipatient 2] ER/Outpatier	nt 3 DOA	Othor		dence 6 □Other (Spe	icify)
J of	ding Phys n. After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c.	Injury at Work?		now injury occurred	
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Division	or Attendential de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined		home, farm, st	reet, factory, of	fice	28f. Location (S City or Tox	Street and Number or R vn, State)	ural Route Number,
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Exa	nysician: To the best of my kn niner: On the basis of examin						
	thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Li	cense number		29d. Date signed (Moni	h, Day, Year)
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	\mathcal{O}_{i}		30. Name and address of person who	7-	m 23a) /Tuna					-
	10		Beh Floro	600 N. WOLF	o Stro	et B	AUTIMOR	e,MD2	11287	
2	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature A	ack s				
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Amend item#18, perFh, 0857, 7/28/06 The and Amend I beginning the second of the second in the second of the second in the second of the second in the second of the

		Amend item#18, peri 1- State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artment of F tificate of	Health and I <i>Death</i>		giene, Reg. No.	2006	20670
		1. Decedent's Name (First, Middle	, Last)					2. Date of De	ath	Vana	3. Time of Death
Physicia /Medic		Estelle Margare	t Simmons	S				June 2	9, 20	Year	9:17 AM M
Examin		4a. Facility Name (If not institution				4b. City, Town, o	or Location of Death	h	4c.	County of Death	1
		300 Stillwater	Road				Essex		Ba	ltimore	
Funeral		5. Social Security Number	6. Sex		. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	9. Birth	nplace (State or Foreign untry)
Director		217-09-0517	1 □ M 2 🗹 F	87	Yrs.		1,0010	08/10/	1918		
pu >		Usual Residence of Decedent 10a. State 10b. County		100.0	ity, Town or Lo	oation					10d. Inside City Limits
show	_					Cation					1 ☐ Yes 2 € No
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with t		10e. Street and Number				10f. Zip Code 21221			USA	zen or wanat con	untry
s 23	Funeral	300 Stillwater 11. Marital Status		cedent Ever in	118 13 1		Hispanic Origin? (S	pacify Yes or No		I4. Race - Amei	ican Indian
ter d	Ē	1 ☐ Never Married 2 ☐ Marr	Armed F	orces?	10.1	f Yes, specify Cub.	lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)		Black, White	e, etc.
urs at	by	3 Widowed 4 Divorced	If Yes, G Year or	ive		I□Yes 2. No	Specify:			Specify: Whi	te
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hin 7	pie	(Specify only highes Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NDT use retire	during most of word)	rking	Own	Home	
giene di Mit	Completed	7			Homem	aker					
al Hy	Be (17. Father's Name (First, Middle,					18. Mother's Nan	·	, Maiden .	Sumame)	
should be filed within 72 hours after death with the Maryland and Mental Hygiene. In a Mental Hygiene. In narked other than "netural; or items 23e or 28e-f show umatic event, the Medical Examinat is ust be indiffed at	일	Charles Walter	S				Agusta	Grau Wi	lkison		
2 sho and and ls m		19a. Informant's Name/Relations					and Number or Ru			_	ip Code)
is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiener. It is marked other than "netural", or thems 23e or 28a-1 show other traumatic event, the Medical Examinations to confide a		Carolyn Waganer/	Daughter	1001			rt Freel				
Pages 1 nent of H nt: If ite		20a. Method of Disposition 1 Burial 2 Defenation	3 □Removal from	t t	cemetery, crer	sition (Name of natory or other pla	ce)	Jun 29		cation - City or I	
. Pa tmen tent: jury		`4 □ Donation 5 □ Other (S		Ch		ce Cremat		2006	Belt	sville,	Maryland
permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tra		21. Signature of Funeral Service	Licensee	MAIL		. Name and Addre	ess of Facility and Funera	al Altern	ative	es	
4 463 64		23a. Part1. Enter the disease, or	ce Kelly	~ 1 1011			Pastures			nore, Man	ryland Approximate
		shock, or heart failure. List	only one cause on	each line.	atri. Do not ent	er the mode of dyll	ng, such as cardiac	or respiratory a	rrest,		Interval Between Onset and Death
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fanding Physicien: The law leading Physicien: The law for: Atter this certificate has to the funeral director, page 2 s	Be (25. Was case referred to medical examiner?						ath (Check only	one)		
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To the Hospitel or Attending Physicien: within 24 hours after death of the Funerel Director; Atter this certifical completely filled in by the funeral director, to	Med	29b. Signature and title of certifie		inioi stateu.		29c. Licens	se number		29d. Date	e signed (Month	. Day, Year)
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1-		30. Name and address of person	who completed as	w t	om 93a) /Tuna	Grint)					
φ		Jude Munese			45 6)AKunda	Rowal	Glow	Bu	Mie n	1D 21061
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		1	For Stete Registrer	State of	Marylar			t of H				Reg. N	1	006	2067
п	Physicia		1. Decedent's Name (First, Middle, LIMAA SMAL	Last)							2. Date of I	D	ay	Year	3. Time of Death
	/Medic Examin	_	4a. Facility Name (If not institution,		nber)		4b. City, 1	Town, or	Location	of Death	00		ප c. Coun	ZOOC nty of Death	, 2231
	LAdiliiii	C1	UNIV MANTLUM				1		mu					timore	
	Funeral				7. Age (In yrs.		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of E (Month,	Day, Yea	r)	9. Birthp	place (State or Foreigntry)
	Director	-	217-44-8542 Usual Residence of Decedent	70 III 2201	60	Yrs.				F	eb. 17	, 194	6		ington, D.C
Popla	Now I		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1	Od. Inside City Limit
Ma	8 - 9 B	ctor	Maryland Anne A	rundal	Lint	hicum									1 ☐ Yes 2 ☐ N
4	a or 2	Die	10e. Street and Number 818 Main Ave. #5				10f. Zip							What Cour	•
die di	ns 234	erai	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.			ispanic Ori	iain? (Spe	cify Yes or I			ace · Americ	
1215-0036	penimic reges i ento solutione line within 72 thous area death with the waryfath population. The solution and Mental Highene. Important: If item 27 is marked other than "naturel; or Items 23a or 28e-1 show any injury or other treumatic event, the Medical Examiner must be notified at ORGE.	by Funeral Director	1 Never Married 2 Married	Armed For	ces? 2 ☑ No		If Yes, speci	ify Cuba	n, Mexicar	n, Puerto F	Rican, etc.)		BI	lack, White,	
003	LETE.	b b	3 ☐ Widowed 4 ₭ Divorced	Year or Da	ites:		1□Yes 2		Specify:				Spec	ALIT	ite
1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	n *nat	piete	15. Decedent's (Specify only highest of	grade completed)		16a. Dece (Give life.	dent's Usual kind of word DO NOT use	l Occupa k done d e retired	ation <i>furing</i> mos)	st of workin	g	16b.	Kind of	Business/In-	dustry
21215-0036	giene er tha	Completed	Elementary/Secondary (0-12) 12	College (1	-40r 5+)	Wait	ress					Res	staur	ant	
pur	od oth	Be	17. Father's Name (First, Middle, La	st)							(First, Midd	le, Maide	n Suma	ame)	
Maryland	marke marke	၉	Earl Lowe Sr. 19a. Informant's Name/Relationship	(Tyne Print)		19h Mailir	an Address	(Street :		Gorou		thor City	or Tour	n, State, Zip	Codel
Za	alth ar 27 le rr treu		Ronald Smallwood	(-),,,,			Piscata				Odentor				(000)
Baltimore,	of He of He of he of he		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3	□ Removal from S		Place of Dispo	sition (Nam natory or oti	e of her place	9)	Da	ate	20c. l	Location	n - City or To	own, State
ti Ti	tment tant:		4 □ Donation 5 □ Other (Spe	cify)		timore \			-		006	Laur	el,	Marylar	nd
Bai	Deper Impor		21. Signature of Funeral Fary Lic	E h	Mh.	F1e		eral	Home	7601 S		_	Road	Laurel	Maryland 2
	hysician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that ca ly one cause on ea	ich line.	h. Do not ent	er the mode	of dying	g, such as	cardiac or	respiratory	arrest.			Approximate Interval Between Onset and Death
	Examiner			Due to (or as a conseq	. 0	41~	10	المراريد	-	()	1/			
7	2 / 5	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (c	or as a conseq						1	1	12	R	
760,	icien end	œ	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (c	or as a conseq	uence of):	-			Λ	$+$ \wedge	4		al Examin	
	hysicie he bur			d						\triangle	/	· · · · · ·	N MED	ilo.	
× 68	ding p	/Med	IF FEMALE:	23c. If yes, outo	ome of oreons	nocy			/	1		OPRC	0		
O. Box 68	signed by the ettending physicien end a signed by the ettending physicien end a be detached for use as the burial-transit	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1☐Live bi	rth 2 ☐ Feta ant at time of d	Ideath 3□	Ectopic pre Other (spe				TIFER	ON APPRO		ate of delive	ny Day Year
, P.O.	ed by	y Ph	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the u	nderlying ca	use give	n in Part I.				use cor	ntribute to th	e cause of death?
ords	been sign										10	Yes 2	No	3 Proba	ably 4 □Unknown
Division of Vital Records, P.O	within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, pege 2 st	Completed									24a. Wa aut per 1 Yes	opsy formed?	- 1	death?	osy findings available of cause of 2 No
Vita	ector.	Be	25. Was case referred to medical examiner?	Hospital:				04-		of Death	Check only				
of Phys	r this	2	1 Yes 2 No 27. Manner of Death	28a. Date o		ER/Outpatien 28b. Time of			4 🗀 Nu		e 5 Res			ther (Specify)
Vision	death. ctor: Afte	Certification:	1 □Natural 5 □ Pending 2 ③Accident investigate	. /	2006	500	M	lc. Injury Work	? 'es 2 [201		FAG		اساد		tains
ivis	ler de lrecto Irecto	tific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	a 28e. Place	of Injury - At ho g, etc. (Specif	ome, farm, stre	et, factory,	office		28	If Location	(Street a	nd Num	ber or Rural	Route Number SLATAWAT
	urs af					Home				Ru	MOR.VE	000	Nto	nmo 2	1113
HOH	within 24 hours after descriptions to the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 Certifying I (Check only one) 1 Medical Ex	hysician: To the laminer: On the ba and mann	sis of examina	wledge, death tion and/or inv	occurred at estigation, i	t the tim in my op	e, date and inion, deat	d place, ar th occurred	nd due to the d at the time	e cause(s	and m d place,	anner as sta , and due to	ated. the cause(s)
To th	within To the		29b. Signature and title of certifier				29c.	License	number			29d. Da	ate signe	ed (Month, L	Day, Year)
Í		(1 / the	7 1.11	,			16	541			0	6/19	1/200	6
			30. Name and address of person wh	completed cause	of death (Item	23a) (Type, I	Print)	1 -	, , , ,				1/1	1	
	6		CASE THOMAS	22 S.	Green	01"	Sal	pur	u, v	MP	212	01			
	Stat Registra	~	31. Date filed (Month, Day, Year)	006	gistrar's Signa	ture									

State of Maryland / Department of Health and Mental Hygiene 🤈 06/2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** 10:380 3.006 ames /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** opkins N/A 7. Age (In yrs. Tast birthday) mor Johns If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Days August 29, 1944 Hours Months North Carolina X1XXM 2□ F 61 156-34-6709 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. Count rthen "naturel", or iteme 23a or 28a-f ehol Ite Medical Examinat must be notified at XXX des 2□No Baltimore Director N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 2805 Elliott Street 21224 death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 12. Ves 2 □ No Vietnam 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: White 1 Yes XXNo Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Risk Management Specialist Risk Management permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other traumatic event, Illis pance. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John James Scott Sr Anne McCready 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wife 2805 Elliott Street Baltimore, Maryland 21224 Cynthia Dwyer Scott 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ★★ remation 3 ☐ Removal from State 20c. Location - City or Town, State 6/30/06 GreenMount Crematory Baltimore, Maryland Donation 5 ☐ Other (Specify) Signature of Funeral Se 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. Respiratory

Due to (or as a consequence of): adays Hrrest **Physician** /Medical Traches-esophageal fistula **Examiner** brobic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Right upper

Due to (or as a consequence of): tomy for lung Concer burial-transit or Attending Physician: The law requires that the death certificate be executed Dex and physician Box 68760, Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No within 24 hours after death.

To the Funerel Director: After this certified completely filled in by the funeral director, i 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient ٩ 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of RES-000 6121106 s ol person who completed cause ol death (Item 23a) (Type, Print) 30. Name and addr Maxhimer 600 yorth wolf Street Baltimore MD. 21287 nitch 32. egistrar's Signature 31. Date liled (Month, Day, Year) State Registrar JUN 3 0

ORIGINAL

		1 - State Registrar	ite of Marylar	nd / Depa <i>Cei</i>	artment of He rtificate of D	ealth and M leath	ental Hygie Reg.	L 0 0 1	5 20673
Physicia		1. Decedent's Name (First, Middle, Last) BRUCE SIV	ELLS				2. Date of Death Month 6 2	Day Year 23 2006	3. Time of Death 1440 M
/Medic Examin		4a. Facility Name (If not institution, give street and Lorien Frankford			4b. City, Town, or E	ocation of Death		4c. County of Dea	uth
Funeral Director		5. Social Security Number 218-12-4443 6. Sex 1XI M 2	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 9-15-2	ar) C	rthplace (State or Foreign ountry) Md.
tryland show		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo					10d. Inside City Limits 1 XYes 2 □ No
ith the Ma or 28a-f s	Directo	Md. NA 10e. Street and Number		BAL	TIMORE 10f. Zip Code 2121:	2	10g.	Citizen of What C	
In all years of the 12-13-13-13-13-13-13-13-13-13-13-13-13-13-	Funeral Director	An	as Decedent Ever in U	J.S. 13.	Was Decedent of His If Yes, specify Cuban		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
hours afte	Ď	A- III]Yes 2 □ No res, Give ar or Dates:		1 ☐ Yes 2½ No dent's Usual Occupat	Specify:	166	Specify: E	Black S/Industry
within 72 ene. than "nai	Completed	(Specify only highest grade com	oleted) llege (1-4or 5+)	(Give	kind of work done du DO NOT use retired)	ring most of worki	ng	Verizon	2 modsky
d be filed antal Hygi ced othar c evant,	To Be Co	17. Father's Name (First, Middle, Last) Mills		Sive		8. Mother's Name	(First, Middle, Maid	den Sumame) Boy	<i>r</i> d
id 2 shoul id 2 shoul ith and Me 27 is mari traumati	Ė	19a. Informant's Name/Relationship (Type, Pri Vivian Sivells	mt) Wife		ng Address (Street ar			-	Zip Code) 21213
Dattillion of was year promit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other traumatic events.		20a. Method of Disposition ↑ Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	20b.	Place of Dispo cemetery, crea	esition (Name of matory or other place) Forest Ve)	Date 20c	Location - City o	
permit. P Departme Importen eny injur.		21. Signature of Funeral Service Licensee	v ane	22	Name and Address	of Facility	Baltimo	ore, Md. E. North	21202
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau immediate Cause (Final	s that caused the dee se on each line.	th. Do not ent	A		or respiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical Examiner		disease or condition resulting in death)	DEMEN Due to (or as a conse		MUYAM	LED			
urted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a conse	quence of):		-			
g physician and as the burial-transit	edical Exa		Due to (or as a conse	quence of):					
ath certificat stending phy or use as th		in the past 12 months?	ves, outcome of pregr	el death 3	Ectopic pregnancy			23d. Date of de	elivery Day Year
at the de de de de de de de de de de de de de	Physician/M	1 7 Vas 2 7 No 4	Pregnant at time of Unknown		Other (specify)	in Part I	23e. Did tobac	co use contribute t	to the cause of death?
w requires that the death certifue on the second sec	ted by	Takin susi signingan sanah sanah sanah					1 ☐ Yes		robably Unknown
	Completed						24a. Was an autopsy performed	prior to death?	
Physicien Physicien this certifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospita	1 Inpatient 2		nt 3□ DOA Other	Nursing Hor	me 5 Residence 28d. Describe how i		ecify)
To the Hospital or Attending Physicien: The lawithin 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	a. Date of Injury (Month, Day Year) a. Place of Injury - At I	28b. Time o	M 1 Y	es 2 No	28f. Location (Stree		Jum I Poute Mumber
pital or A urs after a erel Direc		4 Homicide determined 281 29a. Certifier 11 Certifying Physician	building, etc. (Spec	ify)			City or Town, S	tate)	
thin 24 ho tha Fun mpletely 1	Medical	(Check only 2 Medical Examiner: C	n the basis of examin	ation and/or in	vestigation, in my opi	nion, death occurre	ed at the time, date	and place, and du	e to the cause(s)
/\ \\		OM, MD			Ca	7727	- 6	127/	06
5x,		30. Name and address of person who completed the street of	ed cause of death (ite	nature.	Nasher	PL.	Dands	alk. 1	UD 21222
Sta Registi		JUN 3 0 2006	leave	B A	men				

		1	1 - State of Maryla		artment rtificate				F	Reg. No.	2006	206	74
	Physicia		1. Decedent's Name (First, Middle, Last) Marion R. Sanders						Date of Dea Month INC	ath 27 ^{Day}	2006	3. Time of D	
1	/Medic Examin	al -	4a. Facility Name (If not institution, give street and number) Fairhaven		4b. City, To Syke					4c. (County of Dea		
	Funeral Director		553-26-4650 1□M 2∏F 82	s. last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	Date of Birt (Month, Day ug 21	h y, _{Year)} 1923	C	thplace (State or i ountry) Wa	Foreign
	Maryland -f ehow		100.000	City, Town or Lo								10d. Inside City 1 ☐ Yes 2	
	with the a or 28e	Direc	10e. Street and Number 2028 A Rudy Serra Drive		10f. Zip 0				1	10g. Citiz USA	en of What C	ountry?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or Itema 23a or 28e-f show amy injury or other traumatic event, the Midical Examinational Maryland and once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marned 3 Never Married 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decede If Yes, specif		panic Oric Mexican Specify:	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)		4. Race - Am- Black, Whi Specify: Wh	te, etc.	
21215-0036	vithin 72 houne. ne. hen "nature e Munical E	mpleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use CTSONN	done du retired)	iring most				nd of Business		
	d be filed v ental Hygie ced other t c event, to	To Be Co	17. Father's Name (First, Middle, Last) Urban Rose Trueblood	_ P			18. Mothe	r's Name (F	First, Middle,	Maiden	Sumame)		
Maryland	d 2 shoul th and Me 17 ie mark traumati	Ĕ	19a. Informant's Name/Relationship (Type, Print) Ronald Sanders (son)	19b. Maili 7552	ng Address (Street ar	nd Numbe	ykesv	ille,	er, City or Md 2	Town, State,	Zip Code)	
Baltimore,	bages 1 and the all th		1 M Burial 21 Cremation 31 Removal from State !	Place of Dispo cemetery, cre		_	. ' _	Date 7–3–06			cation - City o	Town, State	
Baltir	permit. F Departme Importar any injur		21. Signature of Funeral Service Licensee Pagy Haught Hubbert		2. Name and							& Chapel	
	Physician		23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. A. A. A. A. A. A. A. A. A. A. A. A. A.						espiratory ai	rrest,		Approximate Interval Betwo	een eath
7	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate Immediate Cause (Final disease) a. Due to (or as a condition or as	sequence of):	Hery	d	13.89	5 L_					
3760,	ate be executed sysicien and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conditional co										
.O. Box 68	The law requires that the death certificate be exite has been signed by the attending physicien bage 2 should be detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ Fegnant at time 9 ☐ Unknown	etel death 3	□Ectopic pre					2	23d. Date of de Month		9 ar
Δ.	urres that n signed by	by	Part II. Other significant conditions contributing to death but not	resulting in the	underlying ca	use give	n in Part I		23e. Did t	/		to the cause of de Probably 4 □Ur	
Vital Records,	The law requir ate hes been si page 2 should	Completed	Chronil ibstructive is	ant.	01	1.5	- On to			an psy ormed?	24b. Were a prior to death?	utopsy findings a completion of cal	vailable use of
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ō	ng Phys (fer this Ineral dii	tion: To	1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	2 ER/Outpatie 28b. Time Injury		Bc. Injury Work	4 LINE	28	5 ☐ Resi d. Describe		6 □Other (Sp y occurred	ecify)	
Division	of or Attendation of the death	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - building, etc. (Sp.	At home, farm, s ecify)	treet, factory	office		28	f. Location (City or To			Rural Route Numb	98r.
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my 2 Medical Exeminer: On the basis of examiner and manner stated.	knowledge, dea nination and/or i	ith occurred a nvestigation,	at the tim in my op	e, date ar inion, dea	nd place, an ath occurred	d due to the at the time,	cause(s) date and	and manner a place, and du	as stated. ue to the cause(s)	
	To the within To the comp	Me	29b. Signature and titl Whifler				number 84	9		-		nth, Dey, Year)	
	le		30. Name and address of person who completed cause of death William Tan MD (6	Item 23a) (Type	Print)	R	3 8	Iden	bus	Mi	21	784	
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's S	ignature	N.								

		-	For State Registrar	State of Mar	•	artment of H		Mental Hygien	- / IIIII	20675
	Physicia	an	1. Decedent's Name (First, Middle Deborah S					2. Date of Death Month June 28	2006	3. Time of Death 8:15p M
	/Medic Examin		4a. Fecility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Deat		c. County of Deat	
	_ Admi	Ĭ.	7436 Brandenbu	rg Circle		Sykesvi			Carrol1	
	Funeral Director		218-70-0015	6. Sex 7. Age 1	(In yrs. last birthday) O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Birti	hplace (State or Foreign
	and **	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl f aho	ō	MD	Carroll		Sykes	ville			1 ∰Yes 2 ☐ No
	r 28a	rec	10e. Street and Number			10f. Zip Code		10g. (Citizen of What Co	untry?
	th wit	a D	7436 Brandenb	urg Circle		2178			USA	
9	within 72 hours after death with the Maryland ene. Itan "natural", or itema 23a or 28a-f ahow Ita Modical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes 27 No If Yes, Give Year or Dates:		Was Decedent of Hilf f Yes, specify Cubai 1 ☐ Yes 2 No	spanic Origin? (§ n, Mexican, Puer Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White Specify: W	
Ş	hour tural'		15. Decedent		16a. Deced	tent's Usual Occupa	ition	16b.	Kind of Business/	
<u>ה</u>	n "na n "na	plet	(Specify only highes		(Give	kind of work done d DO NOT use retired,	uring most of wo	orking		,
7	d with giene	Completed	Elementary/Secondary (0-12)	2		emaker			omestic	
2	2 should be filed within and Mental Hygiene. Is marked other than aumatic avant, ItalMi	Be	17. Father's Name (First, Middle, I					me (First, Middle, Maid	en Sumame)	
yianu	ould b Ment Ment arkac	၉	George Edw		7171000			Jane ?		
	s 1 and 2 should f Health and Men ftem 27 is marks other traumatic		19a. Informant's Name/Relationsh Mr. Mark A. Sc		. 2	•		Rural Route Number, City		
บ้	ss 1 and 3 of Health Item 27		20a. Method of Disposition	iroeder (Spot	20b. Place of Dispo	sition (Name of		cle Sykesvi Date 20c.	Location - City or	
2	Pages nent of int: If it		1 Burial 2 Cremation 4 Donation 5 Other (St		All Count	natory or other place v. Cremati		0/2006 Sw	kesville	MD
Baillimoi	permit. Pages Depertment of Important: If it any injury or o		21. Signature of Funeral Service I		ff	Alghi fun	ERAL HOI	ME & CHAPEL 784 (410)-7	. PA (Bo	
			23a. Part1. Enter the disease, or	complications that caused t	he death. Do not ent				35 1-700	Approximate Interval Between
	Pnysician /Medical Examiner		shock, or heart failure. List Immediate Cause (Finaf disease or condition resulting in death)	a Non-sm	all lung (cancer				Onset and Death 10 months
8700,	deeth certificate be executed e ettending physicien and id for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
O. Box 6		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 Months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		70.	23d. Date of del Month	ivery Day Year
Ĭ.	6 50	۵	Part II. Other significant condition	ns contributing to death but	t not resulting in the u	nderlying cause give	en in Part I.	V		the cause of death?
Records	0 - 0	Completed						24a. Was an autopsy performed 1 Yes 2 ☑	prior to death?	utopsy findings available completion of cause of
or Vital	Physician: Th r this certificate rat director, pag	Be	25. Was case referred to medical examiner?					eath (Check only one)		
5	Physic this c	ပ္	1 ☐ Yes 2 ☑ No	Hospitaf:			4 IVUISHING		6 ☐Other (Spec	cify)
	5 5 5	lon	27. Manner of Death 1 Natural 5 □ Pendin	28a. Date of Injury (Month, Day	Year) 28b. Time o	Worl	rat c? Yes 2 ∐No	28d. Describe how in	fury occurred	
DIVISION	or Attanter deat linactor:	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	not be 200 Place of Injur	ry - At home, farm, sti (Specify)			28f. Location (Street City or Town, St		ural Route Number,
_	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical Co	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physician: To the best of Examiner: On the basis of and manner state	examination and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as	stated. to the cause(s)
	To the within To the	Me	29b. Signature and title of certific			29c. License			Date signed (Mont	
			1///	17		D00550	65	June	29, 200	6
	X		30. Name and address of person							
	. /		Greenebaum C	incer Center	22 S. Gree	ene St N91	E08 Balt	imore MD 21	201	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 3 0 2	.006 Alexandra	r's Signature	de				

			1 - For State Registrar	State of N	Marylan		artment rtificate			ınd M		giene 2	0.0	5 2	0576
	Physici	200	Decedent's Name (First, Middle	a, Last)							2. Date of De Month	ath Day	Year	3. Tie	ne of Death
	/Medic		Ida	Bernice	3		Sa	ove	У		June	18,2		6:	15 A M
1	Examin	er	4a. Facility Name (If not institution	-			4b. City, T	own, or	Location o	f Death		4c. Cou	nty of Dea	ith	
			Clinton Rehab				Clir			· · · · · · · · · · · · · · · · · · ·				Geor	
	Funeral		5. Social Security Number	6. Sex 7		last birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	v. Year)	9. Bir	thplace (S. ountry)	tate or Foreign
Ц,	Director		213-42-5161 Usual Residence of Decedent		65	113.					Febru	ary 2	2Was	ning	ton DC
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					-		10d. Insi	de City Limits
	Mary	ţo	Maryland Prin	ac Coora		linto	n							11	Yes 2 □ No
	1 28a	Director	10e. Street and Number	ice deorge	5.1. <u>C</u>	.111100	10f. Zip (Code				10g. Citizen	of What Co	ountry?	
	3a o		5706 Spruce I	rive			20	735	5			USA			
	deat	Funerai	11. Marital Status	12. Was Decede Armed Force	nt Ever in U	.S. 13.				in? (Spe	cify Yes or No Rican, etc.)	- 14. F		erican India	an,
0	or It	Ē	1 Never Married 2 Marr				irres, speci 1 ☐ Yes 2		Specify:	, Pueno i	nican, etc.)		Black, Whit	te, etc.	
Ξ	ours iral',	d by	3 ☐ Widowed 4 🖾 Divorced	Year or Date	s:		10 105 2	EJ 140	эрвину.			Spe		ack	
21215-0036	be filed within 72 hours after death with the Maryland stal Hygisne. ad other than "natural", or Items 23a or 28s-f show event, the Medical Exacular must be inclified at	Completed	15. Deceden (Specify only highes			(Give	dent's Usual kind of work	done d	urina most	of workir	ng	16b. Kind o	f Business	/Industry	
Z	han han	ם	Elementary/Secondary (0-12)	College (1-4d	or 5+)		DO NOT use	,)				-		
	filed v Hygia other t		1 2 17. Father's Name (First, Middle,	/ netl		Secr	etary	7	10 Matha	da Alama		Feder		over	nment
maryiand	to be	Be		Lasi/	-						(First, Middle,	, Maiden Sun		_	
Ĕ	should be filed within and Mental Hygiane. marked other than umatic event, the M	မှ	ROY 19a. Informant's Name/Relations	nin (Time Drint)	Р	rocto		(0)	Loui					Gree	
Z	2 2 2 3					1					Route Numbe				
	1 and Heelth em 27 ther tr		Joseph Savoy 20a. Method of Disposition	/ Son	20b. F	l 502 Place of Dispo			Lanac		Gree	20c. Locatio	_	- Inggette	Caroli
ĕ	Pages nent of int: If Its ury or o		1X Burial 2 ☐ Cremation			emetery, crei	natory or oth	ner place	9)	_	2.0	200. Locatio	in - Oily of	TOWII, Sta	16 210 x2
Бапптоге,	rtme rtani	. 12	4 ☐ Donation 5 ☐ Other (S		Re	surre					/2006				
n n	Depermine Deperm	1	21. Signature of the state of t	accins be	101	24.0	2. Name and			Ada	ms Fu				
			23a. Part1. Enter the disease, or	complications that caus	191								Mary	Approx	20608
,	Physician /Medical Examiner be executed but it the prival-itansit in the prival-itansit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequential v list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ————————————————————————————————————	as a consequence as a c	uence of):	ZOTIC	CA	ROIO	ASU	ru(A1)	Disea	SE		and Death
P.O. BOX 08/00,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physicien and the Funeral Director. After this certificate has been signed by the ettending physicien and the funeral director, paga 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcom	2 ☐ Feta at time of d	Ideath 3	Ectopic pred	cify)					Date of del	Day	Year
ń	signed bed	ρ	Part II. Other significant condition HYPERTEN		REA		^	ILU LU				obacco use co res 2 🖳			
Ö	w require been si should I	etec	Пуректон	7.0	1/0	VI-L	1731		ICE	_	-		2∐ FI	ODADIY 2	- UONKNOWN
H Records,	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, paga 2 s	Completed		r						_	24a. Was autop perfo	med?	prior to death?	itopsy findi completion 2 \(\subseteq No	ngs available of cause of
DIVISION OF VITAL	lcian certifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Totha			Check only o				
5	Phys this al dir	J.	1 ☐ Yes 2 ☑ No 27. Manner of Death	· 1 lnpa		ER/Outpatien		Care	4 ☑ Nur	sing Hom	ne 5 Resid	dence 6 🗆 C	Other (Spe	cify)	
	ding I	Certification:	1 Natural 5 Pendin		Day Year)	28b. Time of Injury	M 28	c. Injury Work	at ? ′es 2.∐N		8d. Describe f	now injury occ	urred		
2	deat deat ctor: / the	Ica	2 Accident investig 3 Suicide 6 Could r	not be	Injury - At ho	ome farm str			03 2011	_	8f. Location (S	Street and No	mhor or Pr	im! Bouto	Alcomban
3	after Dire	ertii	4 Homicide determ	building,	etc. (Specif	y)	eet, lactory,	OIIICO		-	City or Tox	vn, State)	iliber or no	II AI MOULE	Namber,
_	spite cours neral filled		29a. Certifier 1 Certifyin	g Physician: To the be	st of my kn	Wlados dunii	t (annument si	If a five	a datamen	James 4	rd due to the	Faucalist av 1	n dere is on	nici i	
	Ho.	Medicai	(Check only 2 Medical one)	Examiner: On the basis and manner	or examina	tion and/or in	vestigation, in	n my op	inion, death	occurre	d at the time,	date and plac	e, and due	to the cau	se(s)
	To the Within To the Complex c	Me	29b. Signature and title of certifier						number			29d. Date sig	ned (Monti	h, Day, Ye.	ar)
	. ,,,,,			ATTENDI	v 6 P	HYSIL	AN I	0 5	290	0		6-2	0-21	006	
	5	Ŋ	30. Name and address of person MVSA MOMOH	who completed cause o	f death (Item	23a) (Type,	Print)				ANDOV				•
	Sta	to	MVSA MOMOH 31. Date filed (Month, Day, Year)		strar's Signa	NTRA (L AU	71	، ادد	L	,r(10000		10 21	183	
	Registr		JUN 3 0		_	4. do	ade								

			1 - For State Registrar	State of Mar	yland / [Departme Certifica	ent of Heate of De	alth and eath	Mental Hy	giene Reg. No.	2006	20677
	Physici /Medi		1. Decedent's Name (First, Middle, Las	"Lee	_	Tate			2. Date of De Month	Day 25	Year 06	3. Time of Death 4:05 PM
	Examir Funeral Director		4a. Facility Name (If not institution give FRANKIN 5. Social Security Number 6. Sr 23462-6292 Usual Residence of Decedent	DUARE +	DSPITI In yrs. last bir 67	AU J	OSE der 1 Year III	f Under 24 Hrs Hours Min.	8. Date of Bir		County of Death County of Death South 10 9. Birthp County WEST	ORE lace (State or Foreign try) VIRGINIA
	the Maryland 28a-f show	tor	10a. State 10b. County HARI		Oc. City, Tow	n or Location	ABINGD	ON			1	0d. Inside City Limits
	with the a or 28s	Direc	10e. Street and Number	1		10f.	Zip Code	00		10g. Citiz	zen of What Coun	itry?
980	s 1 and 2 should be filed within 72 hours after deeth with the Maryland Health and Mental Hygene. Item 27 is marked other than "naturel", or items 23a or 28s-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	2715 MERRIK WAY 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evo Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates:	er in U.S.	If Yes, s	pecify Cuban, I		specify Yes or No to Rican, etc.)		U.S.A. 14. Race - Americ Black, White, Specify: WHI	etc.
21215-0036		Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12		16a.	life. DO NOT	vork done duri	on ing most of wo	rking	16b. Kir	OWN HC	•
Maryland	uid be file Aental Hy rked oth tic event	To Be (17. Father's Name (First, Middle, Last) CHARLES	IERMAN	HANSO	1	18	3. Mother's Nar SARAH	ne <i>(First, Middle</i> E.	, Maiden .	Sumame) (BRESSI	ÆR)
Mary	nd 2 shoulth and h		19a. Informant's Name/Relationship (7 SANDRA WISNIEWSKI)		5.9	Mailing Addre			AIR, MI		Town, State, Zip	Code)
Baltimore,	8 = 5		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	20b. Place of cemeter	Disposition (A y, crematory o	ame of rother place)		Date 9-2006	20c. Loc	cation - City or To	
Balti	permit. Pa Depertment important: any injury once.		21. Signature of Funeral Service Vicen		TIDIT	22. Name	and Address o		ACH/ROSE	CDALE	ONSVILLE FUNERAL LE, MD	
	Physicien and Medical be executed by physicien and Medical Examiner set the burial-transitions.	edicai Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last	Due to (or as a c	20-to 2 consequence	on) to	tital	Such as cardiac	g dise			Approximate Interval Between Onset and Death
P.O. Box 6	The law requires thet the death certif He has been signed by the ettending tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetel death	3 ☐Ectopic 5 ☐ Other (2	3d. Date of deliver	ry Day Year
	w requires thet been signed b should be deta	۵	Part II. Other significant conditions or	ntributing to death but n	not resulting in	the underlying	cause given in	n Part I.		obacco us	se contribute to the	e cause of death?
of Vital Records,	: The law r cele has be page 2 sh	Completed									24b. Were autop prior to com death? 1 \(\subseteq \text{Yes} \)	sy findings available inpletion of cause of
Vite	Physician: T this certifical ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:			Differen		th (Check only o			
lon of	şt sir	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☑ Inpatient 28a. Date of Injury (Month, Day Ye	28b. T	tpatient 3 [[ime of njury M	28c. Injury at Work?		ome 5 Resid		Other (Specify, occurred)
Division	s after de b Directo ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, fai Specify)	rm, street, facto	ry, office		28f. Location (S City or Tox	Street and vn, State)	Number or Rural	Route Number,
	To the Hospital or Attending P. within 24 hours after death. To the Funeral Director: After the complete y filled in by the tuneral	Medical (29a. Certifier 1⊠ Certifying Phy (Check only one) 2 ☐ Medical Exam	rsician: To the best of miner: On the basis of ex and manner stated	amination and	, death occurre	d at the time, on, in my opinion	date and place on, death occu	, and due to the rred at the time,	cause(s) a date and p	and manner as sta place, and due to	ited. the cause(s)
	To the within To the Comp	Ž	29b. Signature and title of certifier	<u> </u>		2	228	205		29d. Date	signed (Month, D	Day, Year)
	12		30. Name and address of person who d	ompleted cause of deat	h (Item 23a) (Type, Print)	11:2 50	21.00	de D	0 1	c) 10,	71-27
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Societies.	111 3	N. Maria		. (1)(1)	ORCH (11)	Oay, Year)

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:00 ALEXANDER M. TEZAK 27 206 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7008 MARIETTAAUE PARKUILLE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 01/01/1925 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Hours Min Yrs. Director 219-18-0776 81 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7008 Marietta Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If #es, Give Year or Dates: WWTT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: þ 3 ₩Widowed 4 Divorced WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Depertment of Health and Mental Hygies Importent: If Item 27 is marked other the eny Injury or other traumatic event, Ills 2008. 12 Steel Worker Tandem Mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stanislaus P. Telak Alesandra Jazwinska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Gossman - Daughter 3405 Northwind Road Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) 07/01/2006 Gardens of Faith Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 2123 athlew a Weber 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Anirepla 1 worth /Medical Due to (or as a consequence of): Examiner Preleulemic State year, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): ettending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the eld be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Court 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No CAC 24a Wasan hes Ashes Losu 1 ☐ Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ☐ ER/Outpatient 3 DOA Certification; 27. Manner of Death 28a. Oate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation Injury death. Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, Iarm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide fo to. within 24 hou. the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kly D0031295 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BLUD, P.O.B. Ste 208A, BALTO, MO 21237 WENDY KLOESZ, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 3 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 20579 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 27, 2006 **Physician** Year BOW KEN TOM 8:00AM M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 617 Luther Street Brooklyn Park Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2XF China Yrs 80 Sept. Director 216-36-1372 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or ttems 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 27 No Directo Maryland | Anne Arundel Brooklyn Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 617 Luther Street U.S.A.

14. Race - American Indian,
Black, White, etc. 21225 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Chinese 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Proprietor Restaurant permit. Pages 1 and 2 should be filed w Depertment of Health and Mental Hygier Important: if Item 27 ts marked other it eny injury or other treumalic event, Im-17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Cheong Hen Lee Toy Hen Hom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, Maryland 21044 Kenneth S. Tom 7123 Rivers Fdge Road (son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-30-06 Baltimore, Maryland Lorraine Park Cem. 21. Signature of Funeral Service Licensee ²² Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21212 remarse 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ONGESTIVE MONTH. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien end the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical ettending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year 4☐ Pregnant at time of death Day 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ page 2 should be 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy 1□ Yes 20 No 1 Yes 2 No Hospitat or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes √2 ☑ No Certification: To After this 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending To the Hospitat or Attendivition 24 hours after death.
To the Funeral Director: A completely filled in by the fi death. 1 ☐ Yes 2 ☐ No 2 Accident investigation M 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) JUNE 28, D51104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VE MULAKONDA Swite 208, 16 31. Date filed (Month, Day, Year) 1600 RAIN HIGHWAY GLEN BURNIE egistrar's Signature... State JUN 3 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2000

	•	For State Registrar	Otate of Ma	ryland / De	Certificate of	Death		leg. No.	20680
Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th 23 ^{Day} 2006	3. Time of Death
/Medic	al	Mamie 4a. Facility Name (If not institution, give si	reat and numbers		Thompson	n Location of Death	6	23 2006 4c. County of Dea	
Examin	er	Worthington Ass		J	Rei	isterstown		Baltim	ore
Funeral Director		5. Social Security Number 419-30-1131 Usual Residence of Decedent	7. Age	(In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 7-20		rthplace (State or Foreign country) Ala.
yland		10a. State 10b. County		10c. City, Town o	r Location				10d. fnside City Limits
e Mar	ctor	Md. Baltim	ore	Rei	sterstown				1 □ Yes 2X No
3e or 28	i Director	10e. Street and Number 64 Main Street			10f. Zip Code 2113	6		10g. Citizen of What C USA	ountry?
death	Funeral	11. Marital Status	2. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of H	dispanic Origin? (Spe	ecify Yes or No-		
and yearly 2 12 12 12 12 12 12 12 12 12 12 12 12 1	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes WNo If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:			Black
netu netu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. D	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	oation during most of worki	ng	16b. Kind of Business	s/Industry
withir iene. than	ошо	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+	-)	mestic	۵)		Other Per	ople Homes
other vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,		Space Homes
y ould b Mente	To	Dover		ompson		Annie			ngton
and 2 sh waith and n 27 is m		19a. Informant's Name/Relationship (Type Ronald Thompson	e, Print) Son		Sailing Address (Street 82 Tufted)				Zip Code)
permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any Injury or other traumatic events.		20a. Method of Disposition 1	moval from State	cemetery,	isposition (Name of crematory or other pla Mem. Park	ce) 6-29-	-06	20c. Location - City o	_
permit. P Departme Importer eny injur		21. Signature of Funeral Service License	9		22. Name and Addre	ess of Facility	Bal	timore, Mo	. 21202
a goesa		Slady 1	Come	the death. De sei	March F.I			E. North A	
Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ATHEROS	CLEROT	TL CER		-	R DISTAS	Approximate Interval Between Onset and Death
Examiner			Due to (or as a	consequence of)					
/¤ ≒	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of)	•				
ificate be executed by physicien and as the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence of)					
e be ex sicien e burial		€ d.							
ng phy	Medi	IF FEMALE:							
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death. To the Funarei Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of the complete of the comp	Fetaf death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of de Month	olivery Day Year
ires that signed by	þ	Part II. Other significant conditions conf DUS PHACD A	ributing to death but	not resulting in th	ne underlying cause giv	en in Part I.		bacco use contribute t	o the cause of death?
w requir been si should is	letec						24a. Was a		utopsy findings available
Attending Physicien: The lay ar death. ector Atter this certificate has by the funeral director, page 2	Completed						autop: perfor	med? prior to death?	completion of cause of
sician certifi rector) Be	25. Was case referred to medical examiner?	ospitaf:	• • • • • • • • • • • • • • • • • • •	Ott Ott	26. Place of Death			
g Physical this	n; To	27. Mapmer of Death	1 ☐ Inpatien 28a. Date of Injury (Month, Day		ne of 28c. Injur	4 Li Nui sing Hor		ence 6 Other (Spe ow injury occurred	эспу)
ending feath.	catio	Natural 5 Pending 2 Accident investigation	(Month, Day	1627		Yes 2 □ No			
s efter de la la la la la la la la la la la la la	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, farm (Specify)	, street, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	tural Route Number,
To the Hospitel or Attendi within 24 hours efter death. To the Funarel Director: A completely filled in by the tu	edical	29a. Certifier	ician: To the best of er: On the basis of and manner stat	examination and/	death occurred at the til or investigation, in my o	me, date and place, a opinion, death occurr	and due to the c ed at the time, c	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	Calena	lu-i	29c. Licens	se number	ž	9d. Date signed (Mon	th, Dey, Year)
7		30. Name and address of person who con	npleted cause of de	ath (Item 23a) (Ty			AVE	BALTO	MD21208
Sta	ate	31. Date filed (Month, Day, Year)	32. Redistra	's Signature -	-1-4.	, -19/1/3	. , ,	1,40	207-01
Regist	rar	JUN 3 0 20	06 Slow	w D.	green				

06-04446 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Nicholas Taylor 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ June 25, 2006 1115 hrs Taylor Medical Examiner Nicholas 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) NA **Baltimore City** University Hospital 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6. Sex **Funeral** oreign Days Hours Months Director 213-75-8625 Country) Md. 02-14-2006 $_{1}X_{M}$ Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Baltimore 28a-f show Md. NA or items 23a or 28a-f shormust be notified at once. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Healigh and Mental Hygiene
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 USA ā 1900 Howard Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12 Was Decedent Ever in U.S. Funera 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 Married 2 X No Yes f Yes. Give Year 1 Yes 2 X No specify: Specify: Black 3 Widowed Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) NA Infant Infant 1B.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Taylor Devron D. Romingo Steve Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Devron N. Taylor Mother 1600 Rutland Ave., Baltimore, Md. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 2 Cremation 3 Removal from State 6-28-06 King Mem. Pk. Randallstown, Md. Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. ade wane 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Sudden unexplained death in infancy (SUDI) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED signed by the attending physician a be detached for use as the burial -AMENDED iten#23a,27,28a-f,perME,g859,9/18/06 TT Box 68760, 23d Date of delivery IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Year Live birth Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available certificate has been prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: this 1 🗸 Yes 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 2Ba. Date of Injury (Month, Day, Year) 27. Manner of Death Certification Natural Division 1 Yes 2 X No 5 Pending Fnd 6/25/2006 unk the Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) .1506 Pennsylvania Ave. Apt. 9, Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be determined (Specify) House Fo the Funeral 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 26, 2006 O.C.M.E.

State Registrar

Registrar's Signature 31. Date filed (Month, Day, Year)

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD.

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JUNE 27, Ø3:08P M **Physician** 2006 Joseph Topa, Sr. Beniamin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Saint Joseph Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan 9, 1926 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days 1(¥M 2□F 79 219-18-6871 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits the Maryland 10a. State 10h County iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 Tyes 2 No Rosedale Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 21237 USA 9213 Nottingwood Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married ō 1 ☐ Yes XXNo Specify: Specify: White Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Baltimore City al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dept.of Education Electrician permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if item 27 ie marked other it: eny injury or other traumatic event, IDs 2002. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Penczak Anna Topa John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9213 Nottingwood Rd Baltimore, Md 21237 Hazel Topa (wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition MBurial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Mary July1,2006 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee tendos 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Final disease or condition resulting in death) a CARDIAC ARREST CURRENT Priysician /Medical Due to (or as a consequence of): 2 HOURS Examiner CARDIOGENIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed SEVERE AORTIC STENOSIS 5 YEARS resulting in death) Last Due to (or as a consequence of): Box 68760, RECURRENT CORONARY ARTERY DISEASE 10 YEARS Physician/Medical the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CONGESTIVE HEART FAILURE Completed 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 2 Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. spitel or Attendii lours after death. neral Director: A investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) JUN 3 0 2006

LASCHINGER,

29b. Signature and title

30. Name an Address of person

C

W.D. 7601 PREME

mpleted cause

OSLER DRIVE

29c. License number

D40372

29d. Date signed (Month, Day, Year)

TOWSON, MARYLAND 21204

o death (Item 23a) (Type, Print)

		1	For State Registrar	State o	of Maryland		artment of H tificate of I			iene _{eg. No.} 2	006	20683
	Physicia	in i	I. Decedent's Name (First, Middle	, Last) IADINE W	ALLS				2. Date of Deat Month	Day 28	Year 06	3. Time of Death 1:35A M
	/Medic Examin	er	a. Facility Name (If not institution GOOD SAMA)		timber) HOS PI7 7. Age (In yrs. la:			Location of Death			ty of Death 9. Birthp	olace (State or Foreign
	Funeral Director		5. Social Security Number 213-30-4997	1 M 2 XF	70	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month Day) DeC • 27,	1935	Mar	yland
	death with the Maryland me 23a or 28a-f ehow rmust be notified at		Usual Residence of Decedent 10a. State 10b. County MD		10c. City,	Town or Lo	Baltimo	ore			1	1
	ith with the Maryla 23a or 28a-f ehov	i Direc	10e. Street and Number 6110 Marietta	Avenue			10f. Zip Code	21214	1	0g. Citizen o U	f What Coul	ntry?
336	s after or ite	by Fur	11. Marital Status 1 □ Never Married 2 【 Married 3 □ Widowed 4 □ Divorced	Armed F ned 1 ☐ Yes	2 ∏X io iive		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		ace - Americack, White,	
Maryland 21215-0036	.60	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)		(1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired ecretar	during most of world)	king	16b. Kind of St. Dc		dustry c's Schoo
and 2	00.	To Be Co	17. Father's Name (First, Middle, Michael S)	Last) peranzel	.la			18. Mother's Nam Marga:	ne (First, Middle, ret Win	Maiden Sum I KS	ame)	
Mary	id 2 shoul Ith and Mi 27 Is marl traumati		19a. Informant's Name/Relations Robert Lee I	hip (Type, Print) Valls-sp	ouse	19b. Maili 611	ng Address (Street O Marie	and Number or Ru tta Ave	rai Route Numbe nue-Bal	r, City or Tow timor	m, State, Zij e , M D	21214
Baltimore,	permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event <u>once</u> .		20a. Method of Disposition 1 □ Burial 2 X X remation 4 □ Donation 5 □ Other (5	3 □Removal from	- CA		osition (Name of matory or other pla UNL CEIII	etery 7-	Date 3-06	20c. Locatio Balti		
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service	NC 1	du	8	2. Name and Addre	ss of Facility Ford Ro	ANS CHA ad-Park	PEL C	F ME	MORIES 21234
	Physician		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition	t only one cause on	caused the death each line.			ng, such as cardiad	or respiratory an	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner	i i	resulting in death) Sequentially list conditions,	b E	nd S	stag		mal	Disc	ease		
	cuted nd Add	amine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Ś 。	o (or as a consequ							
3760,	ate be executed whysician and the burial-transit	lical Ex	resulting in death) Last	d	o (or as a consequ	ence or).				<u> </u>		
D. Box 68	as as	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ₩0 9 □ Unknown	1 Live	outcome of pregnate birth 2 Fetal ognant at time of de known	death 3	□Ectopic pregnand □ Other (specify) _	у			Date of delige Month	very Day Year
ds, P.O.	ires thet the signed by	Ď.	Part II. Other significant condit	ions contributing to	death but not resu	ulting in the	underlying cause gi	ven in Part I.				the cause of death?
Division of Vital Records,	The law requires te has been sign age 2 should be	Completed							24a. Was autop perio 1 🗆 Yes		prior to c death?	opsy findings available ompletion of cause of
/ital	ysician: The is certificate hi director, page	Be	25. Was case referred to medic examiner?	Hoopitali			0:	has	ath Check only o		Out (C	4.1
n of \	ding Physi h. Atter this c	ion: To	1 ☐ Yes 2 ☐ Mo 27. Manner of Death 1 ☐ Natural 5 ☐ Pend	28a. Da ing (M	te of Injury lonth, Day Year)	ER/Outpati 28b. Time Injury	of 28c. Inju	4 Nursing i	dome 5 Resident			ny)
Divisio	I or Attendi	Certification:	3 Suicide 6 □ Coule	d not be mined 28e. Pla	ace of Injury - At ho Ilding, etc. (Specif)	ome, farm, s	street, factory, office		28f. Location (City or Tox	Street and Nu wn, State)	ımber or Ru	ral Route Number,
	Hospite 4 hours Funere (ely fille	edical C	29a. Certifier 1 Certify (Check only one)	ing Physician: To al Examiner: On the and m	the best of my kno basis of examina anner stated.	wledge, de tion and/or	ath occurred at the tinvestigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and date and plac	manner as ce, and due	stated. to the cause(s)
	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certific	A 1-11	(A (9609)) M.	29c. Licer	se number		29d. Date sig	gned (Month	
	4			nehta,	ause of death (Item	23a) (Typ	e, Print) I RAVEN	BLUD; ?	BALTIMO	ore,	MD	21239
	S Regis	tate trar	31 Date filed (Month Day Yes	32 0 2006	2. Registrar's Signa	ature	hails ,					
	OHMH 17 Rev 1			3		Day of						

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar		artment of Health and rtificate of Death	Mental Hygie	_ < U !! t	2068
	Physici /Medic		Decedent's Name (First, Middle, Last) HELEN BUFFING	TON WARD		June 28,	Day Year	3. Time of Death 3:00P M
	Examir		4a. Facility Name (If not institution, give street and I Blakehurst	number)	4b. City, Town, or Location of Dea		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 3√√ F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birth 1,1910 Man	place (State or Foreign intry) Yland
	e Maryland 8a-f show Illied at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore	10c. City, Town or Lo	cation			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with th	Funeral Director	1055 West Joppa Road		10f. Zip Code 21204	10g	. Citizen of What Co. USA	intry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "neturel" or Items 23e or 28a-f show entry injury or other traumatic event, Ire Modical Examinant must be notified at once.		Armed	S A(A) No Give	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puei 1 ☐ Yes 2 XX Io <i>Specify:</i>	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	d within 72 ho piene. r then "netur the Medical	Completed by	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College 4	(Give /ife.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	b. Kind of Business/li Advertisir	,
Maryland 2	should be filed and Mental Hygi marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) ROSCOE Pierce Buffingto		18. Mother's Na	me (First, Middle, Ma Brightman		
	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Type, Print) Mark H Ward	Son 2314	ng Address (Street and Number or R Merrymans Mill R			
Baltimore,	Pages 1 ment of Hi ent: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2	GreenMoun	natory or other place) it Crematory 6/3	0/06 B	altimore,	Maryland
Balt	permit. Departr Importe eny inj		2) Signature of Funeral Service Licensee	nackes		Road Baltimo	re, Maryland	
	Physician /Medical		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of the disease or condition resulting in death)	t caused the death. Do not ent each line. Chamic Cordio o (or as a consequence of):	1	c or respiratory arrest		Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, fl any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	o (or as a consequence of): o (or as a consequence of):				
P.O. Box 68	e death certifi he attending I led for use as	Physician/Med	in the past 12 months?	gnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deliv	rery Day Year
	w requires that the been signed by t should be detach	ed by Pł	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.	\ -	co use contribute to	the cause of death?
al Records,		Completed by				24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
n of Vital	Phy this rald	on: To Be	27. Manner of Death 28a. Da	Inpatient 2 ER/Outpatier of Injury onth, Day Year) 28b. Time of Injury	t 3 DOA Other: 4 Nursing I	ath (Check only one) Home 5 Residence 28d. Describe how		fy)
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pla	ce of Injury - At home, farm, str Iding, etc. (Specify)	M 1 Yes 2 No	28f. Location (Stree City or Town, S	t and Number or Rur Itate)	al Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical C	(Check only / 2 Medical Examiner: On the	he best of my knowledge, death basis of examination and/or in anner stated.	n occurred at the time, date and place vestigation, in my opinion, death occ	a, and due to the caus arred at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier		29c. License number (D 58303		Date signed (Month,	
	6		30. Name and address of person who completed co	6601 N. Cl	revies St BART	nors me	21204	
	Sta Regista	_	31. Date filed (Month, Day, Year) 32	Aggistrar's Signatur	2500			

Amend item 10c per aft /8856 6-30-06 yet and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year WARD 2006 03:13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner RHOHIE HOSPICE NA BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country)

VA 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛣 F 227. 26.0495 Yrs. Director 83 05.31.1923 Usual Residence of Decedent 10b. County Show 10a. State 10c. City, Town or Location 10d. Inside City Limits If Itam 27 is marked other than "natural", or Itema 23a or 28a-f shov or other traumatic event, Ita Madical Examinar must be notified at Halethorpe Director 1 Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? MONUMENTAL ROAD 21227 2000 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 10 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: BLACK þ 3 Widowed 4 N Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GARMENT RETAIL INSPECTOR 12 1H GRADE NA 17. Father's Name (First, Middle, Last) UNK permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any jury or other traumatic event gone. 18. Mother's Name (First, Middle, Maiden Sumame) MARTHA WARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 MONUMENTAL RD. HALTHORPE MO
ce of Disposition (Name of Date 20c. Location - City or Toy (DAUGHTER) ALMA PAYLOR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 07.01.06 4 ☐ Donation 5 ☐ Other (Specify) MEADOWRIDGE ELKRIDGE , 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO, NATO PIKE, BALTO, MD 2122 21. Signature of Funeral Service License Vaughn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Interval Between Offet and Death Immediate Cause (Final disease or condition resulting in death) Metastat of Concinona Physician MUS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Physician/Medical the as attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 204 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 ☐ No 2 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (M, nth, Day, Year) se of death (Item 23a) (Type, Print) 30. Name and address of person who mo 31. Date filed (Month, Day, Year) 32. istrar's Signature State Registrar

			For State Registrar	State of Maryl		artment rtificate				giene 2	006	20686
	Physici	20	Decedent's Name (First, Middle, Last)	CD.					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		ROBERT LEE WILCHER			45 Oib.	Faura au	Location of D	June	29	2006 ity of Death	6:50am M
	Examin	er	4a. Facility Name (If not institution, give str			_	eda		Jaki i		timor	
	Funeral		5. Social Security Number 6. Sex	7. Age (In)	yrs. last birthday)	If Under	1 Year	If Under 24 I	Irs. 8. Date of Bir	th	9. Birth	place (State or Foreign intry)
	Director		219-12-5547 ^{1Δ1}	^{M 2□ F} 84	Yrs.	Months	Days	Hours N	Aug. 3	0,1921	Geo	orgia
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	ocation						10d. Inside City Limits
	Maryland -f show	ō	Maryland Baltimon	re	,	Ba	ltin	nore Co	unty			1 Tes 2 No
	r 28a	Funeral Director	10e. Street and Number			10f. Zip	Code			10g. Citizen o	f What Cou	intry?
	death with the rms 23s or 28s r.must be not	ai D	3 Rock Creek Ct. Ap	ot. 2A			21	L234		USA		
	ems ams	ner	11. Wantai Status	2. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Deced If Yes, spec	ent of Hi ify Cuba	spanic Origin' n, Mexican, P	(Specify Yes or No Lerto Rican, etc.))- 14. R	ace - Ameri lack, White	
36	hours after tural', or Ita	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give WW Year or Dates:	11	1□Yes 2	No 🌋	Specify:		Spec	cify: Wh	nite
8	stural	ed t	15. Decedent's Educa	ation	16a. Dece	dent's Usua	l Occupa	ation		16b. Kind of	Business/Ir	ndustry
7- 215	hin 72 a. nn na Medic	plet	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)				luring most of	working			
213	filed within Hygiene. ther then and.	Completed	6th grade	N/A	Blad	cksmit	h			Bethle		Steel
Wilcher, Robert Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other treumetic event. If a Medical Examinar must be notified at once.	To Be	17. Father's Name (First, Middle, Last) William Wilcher						Name (First, Middle a Jones	, Maiden Sum	ame)	
_ Sary	2 should have and have le ma	1 15	19a. Informant's Name/Relationship (Type			-			r Rural Route Numb		m, State, Zi	ip Code)
2 €	and lealth m 27 her tr		M. Annette Marsh (more, Md.	21236 20c. Location	n - Ciby or T	Town State
Cl	in of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	b. Place of Disponentery, cre lolly Hi	matory or o	her plac	9) 7		Baltin		
Wilcher, altimore, Mary	it. Pa ritmer ortant njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee							Darth	nore,	Mu.
Ba Z	Depart Impo		> E. J. Lass	// /		lassa 7401	nn F Bela	vneräl ir Rd.	Home Baltimor	e, Md.	21236	3
760,	Physician / Medical Examiner Associated and privial-Iransit on the privial-Iransit on the privial-Iransit on the privial-Iransit on the privial-Iransit on the privial in	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a cor	nsequence of):	onpri	mari	y with t	netastat	-1C +0 liv	100	6 months
Вох 68	or Attanding Physician: The law requires that the death certilical uter death. Director: After this certificete has been signed by the attending phy in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pr □ Other (sp					Date of delin	very Day Year
s, P.O.	res that the igned by be detact	þ	Part II. Other significant conditions conf	ributing to death but no	t resulting in the I	underlying c	ause give	en in Part I.	./	tobacco use co Yes 2□No		the cause of death?
ord	v require been sign	eted							24a. Was			topsy findings available
l Rec	The law sete has page 2 s	Completed							— auto		prior to codeath?	ompletion of cause of
/ita	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	anital. /			100		Death (Check only	one)		
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uo	ding F h. After funera	ion	1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	ar) Injury	M	8c. Injun Worl	γαι k? Yes 2⊡No	200. Describe	now injury occ	Julieu	
Division of Vital Records,	or Attenditer death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, s					(Street and Number, State)	mber or Ru	ral Route Number,
۵	To the Hospital or Attent within 24 hours after deatl To the Euneral Director: completely filled in by the			ician: To the best of my er: On the basis of exa								
	the Ho hin 24 the Fu	Medical	29b. Signature and title of ceptrier	and manner stated		-						
	or the contract of the contrac	-	250. Signature and tipe of certifier	/ (///.		7	. LIUGHS	0/01/	~ >		20	2046
	1		30. Name and address of person who con	moleted cause of death	(Item 23a) /Type	. Print)		604	> \	6-0	7-	2006
0	14		1 0	liuris, 9	000 Fm	inklin	Sam	are Ari	re. Baltin	nore MD	2123	7
		ate	31. Date filed (Month, Day, Year) JUN 3 0 2008	32 Registrar's	Signature	ast,	U		53 ve, Baltin			
	Regist	Well.	2014 2 0 2000	The state of the s	20 Page	The state of the s						

			1 - For State Registrar	State of Mary	land / Depa		Health and	d Mental Hygi	ene 20	06 20687
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give s Holy Cross Rehab	nen			or Location of De	2. Date of Death Month June	Day Y	
	Funeral Director		5. Social Security Number 6. Sex 126–18–4950	7. Age (In 80	yrs. last birthday) Yrs.	If Under 1 Yea Months Day	r If Under 24 H	8. Date of Birth (Month, Day, 11-08-1	9	D. Birthplace (State or Foreign Country) New York
	within 72 hours after deeth with the Maryland ene. than "naturel", or items 23s or 28s-f show than "maryland Exartal er mittal be notified at	ector	Usual Residence of Decedent		c. City, Town or Lo	r Spring		10	g. Citizen of Wh	10d. Inside City Limits 1 Tyes 2X No
	seth with ti s 23s or 2	eral Dire	10e. Street and Number 13223 Conductor W	ay 12. Was Decedent Ever	in II S 13	10f. Zip Code	20904		USA	American Indian,
980	ours after de ref', or item Eza ur er i	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	1942	If Yes, specify Cu		(Specify Yes or No- lerto Rican, etc.)	Black,	White, etc. White
21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use reti	upetion se during most of red)	working	6b. Kind of Busi	ness/Industry unting
Maryland 2	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28a-f show important: If item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examater must be notified at once.	To Be Co	17. Father's Name (First, Middle, Last) Charles W. Wannen	Sr.	ACC	Ouncant		Name (First, Middle, Maret Kennar	aiden Sumame)	
, Man	and 2 sho laith and I 27 is mu er trauma		19a. Informant's Name/Relationship (Ty Mary Helen Wannen	/wife	1322	3 Conduc	ctor Way	Rural Route Number, Silver Spr	ing MD	20904
Baltimore,	Pages 1: nent of He ant: If item arry or oth		20a, Method of Disposition 1 Burial 2 Cremation 3 P 4 Donation 5 Other (Specify)	temoval from State	Ob. Place of Dispo cemetery, cre Chesapea	osition (Name of matory or other p ke Crema	atory 06	Date 2 5-29-2006		ity or Town, State 11e, MD
Balt	permit. Departr Importe eny inje		21. Signature of Funeral Service License	- ZMJ358	2:	2. Name and Add Rapp Fur 933 Gist	ress of Facility neral & (. Ave Si	Cremation S Lver Spring	Service	910
9/	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition	ications that caused the ne cause on each line.	death. Do not en	ter the mode of d	ying, such as card	diac or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner	ler	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co						
760, 💉	certificate be executed iding physicien and ise as the burial-transit	ical Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					
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0	w requires that the death been signed by the atte should be detached for	d by Ph	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the u	inderlying cause	given in Part I.		acco use contrib	ute to the cause of death?
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	Ne Hospil	edicai		sician: To the best of m iner: On the basis of exa and manner stated.						
	vithir to th	×	29b. Signature and title of certifier			29c. Lice	ense number	29	d. Date signed ((Month, Day, Year)
	J		30. ame and addre s of person who	me-12	2011	Print)	1000	SNE	BAZE	MORE MO
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Redistrar's	Signature	Sparle				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State of Registrar	Maryland / Depa	artment of Healt rtificate of Dea			iene 2 (005	2058
	Physici		Decedent's Name (First, Middle, Last) Ellen Rae Willard				2. Date of Death Month	_Dav		3. Time of Death 20.03 M
	/Medio Examir		4a. Facility Name (If not institution, give street and num Union Memorial Hospital	nber)		timore	00	4c. County		
	Funeral Director		5. Social Security Number 396.40.3509 6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year If Un Months Days Hou		8. Date of Birth (Month, Day, 07/06/	^{Y_{θar)}} 1942	9. Birthplace Country)	e (State or Foreign
	e Maryland Be-f show	Director	10a. State 10b. County MD Baltimore	10c. City, Town or Lo						Inside City Limits 1 Yes 2 No
	h with th		10e. Street and Number 6422 Baltimore National	Pike	10f. Zip Code 21228			g. Citizen of V JSA	What Country?	?
036	be filed within 72 hours after deeth with the Maryland stal Hyglene. Id other than "natural", or items 23e or 28e-f show avent, I're Madical Examination in its incities at	by Funeral	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Dece Armed For 1 Yes 1 Yes 15 Yes 17 Yes 18 Yes 19 Yes 10 Year or Da	ces? 2 No	Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 ☑ No Specify	xican, Puerto P	cify Yes or No- Rican, etc.)	Blac	e - American I ck, White, etc.	Indian,
21215-0036	d within 72 ho giene. rr than "natur rr than "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	4or 5+) (Give	dent's Usual Occupation kind of work done during i DO NOT use retired) as Manager	most of workin	g 1	6b. Kind of Bu JS Gove		try
yland	should be filed and Mental Hygin marked other umatic avent, II	To Be C	17. Father's Name (First, Middle, Last) Russell Willard				(First, Middle, M Unknown	aiden Sumam	(8)	
Man	s 1 and 2 should f Health and Mer flam 27 is marks other traumatic		19a. Informant's Name/Relationship (Type, Print) Michael Ahl		ng Address (Street and Nu Sykesville					
Baltimore, Maryland	Pages 1 and 2 nent of Health a int: if Itam 27 is iry or other tran		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)		sition (Name of natory or other place) ke Crematory		Jun I 🤇 📑	Oc. Location - Beltsvil		
Balti	permit. Pages 'Depertment of Himportant: if Ita any injury or of once.		21. Signature of Funeral Service Licensee	7/21/1/1/2	Name and Address of Fa Tremation and 3717 Green Pas				, Maryl	and 21286
	Physician /Medical		23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition resulting in death)	iused the death. Do not ent ich line.	er the mode of dying, such	as cardiac or	respiratory arres	st,	Inte	proximate erval Between set and Death
8760,	Examiner	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	or as a consequence of): or as a consequence of): or as a consequence of):	stery P	sisea.	se			
P.O. Box 6	thet the daath certific hed by the attending p detached for use as	Physician/Mec	in the past 12 months?	int at time of death 5	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery onth Day	Year
	quires thet n signed b uld be deta	þ	Part II. Other significant conditions contributing to dea		nderlying cause given in Pa	art I.				ause of death?
al Reco	sician: The law require s certificate has been sig lirector, paga 2 should b	Completed	Hypertension Chamic Obstactive	e Pulmonan	1 Diseas	e	24a. Was an autopsy perform	ed?	Vere autopsy prior to comple leath?	findings available etion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death. To the Funeral after death. To the Funeral Infactor. Attenthis certificate has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be detached for use as the burial-transit	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 In In In In In In In In In In In In In	patient 2 ER/Outpatien Injury , Day Year) 28b. Time of Injury	Other	Nursing Home	Check only one e 5 Resider 8d. Describe how	nce 6 ⊡Othe		
Divis	tal or Atta s after de al Diracto ed in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place buildin	of Injury - At home, farm, strug, etc. (Specify)	eet, factory, office	28	Bf. Location (Stre City or Town,		er or Rural Ro	oute Number,
	To the Hospital within 24 hours To the Funeral completely filled	dicai	29a. Certifier (Check only one) 1 Certifying Physician: To the tage of the desired form of the bag and manner.	sis of examination and/or inv er stated	estigation, in my opinion,	death occurred	d at the time, dai	te and place, a	and due to the	1. cause(s)
)	To th within To th comp	Me	29b. Signature and hitle of certifier MD 30. Name and address of person who completed cause KISHORE SHARMA 31. Date filed (Month, Day, Year) JUN 3 0 2006	Resident	29c. License numb	98 94	6	d. Date signed	(Month, Day,	
	5		30. Name and address of person who completed cause KISHORE SHARMA	of death (Item 23a) (Type, Vhish Me	print) morial Ho	spiral	Ba	1 Fimor	೬	MD
	Sta Registr	te ar	31. Date filed (Month, Day, Year) 32. 36. 31. Date filed (Month, Day, Year) 32. 32. 33. 34. 34. 34. 34. 34. 34. 34. 34. 34	gistrar's Signature	nade	,				

State of Maryland / Department of Health and Mental Hygiene 2006 20689 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day **Physician** 12:15 PM 28, 2006 Hubert M. Warnick June /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Admiral Blvd. Dundalk Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Nov. 17, 1926 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**X** M 2□ F Months 79 Director 220-16-5999 Md Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 ie marked other than "naturei", or iteme 23a or 28a-f show traumatic event, tre Mudical Examinar must be notified at Dundalk Baltimore 1 Tyes 2 XNo Director Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21222 8 Admiral Blvd. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bfack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 72 hours after 1 ☐ Never Married 2 X Married Yes 2 □ No Yes. Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If **Yê**s, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Steel 7 yrs. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jee, Maryla
Jermit. Pages 1 and 2 should be.
Department of Health and Merimportant: If Item 27 Inany injury or or Mentel Annabelle McKintey Wilson Ravenscroft 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dundalk Md. 21222 wife 8 Admiral Blvd. Gertrude Warnick 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State July 1 Sacred Heart of Jesus Dundalk 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Fur eral Service Lice 22. Name and Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final Netastatio **Physician** tsophageal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit ettending physicien and for use as the burial-trans Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. I ate has been signed by the page 2 should be detached Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1□Yes 2□No 3 Probably 4 □Unknown 24a. Was an autopsy performed?
1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: within 24 hours efter death. To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 1 ☐ Yes 2 No 28c. fnjury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ÷ 29b. Signature and titte of certifier 29c. License number 29d. Date signed (Month, Day, Year) MM 053462 30. Name and advress of person who completed cause of death (Item 23a) (Type, Print) DAKWOOD ROOD Glen Parrie MD 21061 1845 31. Date filed (Month, Day, Year) 32 32 Aegistrar's Signature State JUN 3 0 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 20690 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year Dolores Eleanor Weinreich June 27, 9:45 P M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2802 Gray Manor Terr. Baltimore
9. Birthplace (State or Foreign Country) Dunda lk
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea April 18, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ^{Year)} 1937 **Funeral** Hours Days 1□M 2XF 69 Yrs 215-34-0874 Director Md Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show a 23a or 28a-f shortust be notified at 1 ☐ Yes 2√ No Millville Dé. Sussex Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 38 Baltimore Ave. 19970 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status r than "neturel", or Items the Mudical Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Heatth and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event, Illegone. 12 yrs. Bookkeeper Crane Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Oliver Weinreich ပ Audrey Eleanor Krouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2802 Gray Manor Terr. Jeffrey McCall son Dundalk, Md. 21222 20b. Place of Disposition (Name of cometery, crematory or other place)
Bayview Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State June 30, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation /5 ☐ Other (Specify) Baltimore 2006 21. lignature of Funer I Service Leens 22. Name and Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -cer /Medical Due to (or as a consequence of): Examiner letautation Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Due to (or as a consequence of) resulting in death) Last O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has t irector, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 8 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Sons Home Hospital: Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending I Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) S'EBASTIAN JIHN 1)0055171 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boltmare 3023 Menne Castern 3 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 3 0 2006 Registrar

	,		For State Registrar	State of M	arylan	-	artment of tificate o	Health and f Death		jiene eg. No.	200	5 2	069
			Decedent's Name (First, Middle, Las	(t)			***		2. Date of Deat	th		3. Time o	of Death
	Physicia		LILLIE			WII	LIAM	5	JUNE	Day 22	1006	1300	PM
1	/Medic Examin		4a. Facility Name (If not institution, give	street and number,)			n, or Location of Dea			county of Death	<u> </u>	
	LXamin		THE JOHNS	HOPKING	2 H	SPETAL	BAI	-TIMORE	= C1+4		NA		
	Funeral		5. Social Security Number 6. Se			last birthday)	If Under 1 Ye Months Day			Year)	9. Birth	place (State	or Foreign
	Director		237–52–8110 1	□M 2 x F	71	Yrs.	MOITINS DA	ys Hours Will	3-11-			N.C	
	D .		Usual Residence of Decedent		100 Cib	y, Town or Lo	antion					10d. Inside (City Limite
	aryla shov	<u>_</u>	Md 10b. County		100.01	Balt:							2 □ No
	8a-f	Director		7	1	Dait.				On Citin	on of Mhot Cou		
	with ti		10e. Street and Number	Thursday.			10f. Zip Cod	。 1213	'	og. Citiz	en of What Cou USA	ntry?	
	death with the Maryland ms 23a or 28a-f show rmust be notified a	Funeral	2105 E. Oliver S	12. Was Decedent	Supr in 11	C 121		of Hispanic Origin? (Specify Vas or No-	1.	4. Race - Ameri	can Indian	
	item item	nn	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces	?	3.	f Yes, specify C	uban, Mexican, Pue	rto Rican, etc.)		Black, White,		
5	hours after tural', or ite	by F	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2√2 If Yes, Give Year or Dates:			1□Yes ¾□!	No Specify:			Specify: Bla	ack	
9500-5121	n 72 hours after death with the Marylan "naturel", or Items 23a or 28a-1 show edical Examinar must be notified at		15. Decedent's Ed			16a. Dece	tent's Usual Oc	cupation		16b. Kin	d of Business/In	dustry	
2	within 72 ene. then na	ple	(Specify only highest gra	de completed) College (1-4or	5+)		OO NOT use rei	ne during most of wo ired)	orking				
	giene giene	Completed	10th grade			St	eamstre	SS		Hat	zenburg	n ———	
Maryland 2	e filed al Hygi f other vent, I	Be (17. Father's Name (First, Middle, Last)		_				ame (First, Middle, i	Maiden S	,	2100	
<u>a</u>	should be nd Menta ind Menta in marked umatic ev	2	Edgar		Su	tton		Po.	llie		PIO	ore	
a L	2 sho and is mu		19a. Informant's Name/Relationship (7	•	,		-	eet and Number or F					.213
	s 1 and f Health item 27 other tr		Charlie James Wi	Iliams	Husb			. Oliver					.213
9	m O b-		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □	Removal from State		emetery, crer	sition (Name of natory or other)	olace)			ation - City or T		
Ē	. Pa tmen tant: jury		4 □Donation 5 □ Other (Specif)		M		. Mem.	,	28 – 06		rel, Md	21202	
Baltimore,	permit. Page Department i Important: if any injury or once.		21. Signature of Funeral Service Licen	S88				dress of Facility .H. East	1101 E.		e, Md. h Ave.	21204	ŧ.
	40240		23a. Part1. Enter the disease, or comp	alications that cause	d the deat				ac or resouratory arr	act		Approxima	ıte
			shock, or heart failure. List only					aying, soon as cardi	ao or roophatory arr	001,		Interval Be Onset and	tween
,	Physician /Medical		disease or condition resulting in death)	a. Hu	urt	Failu	ine					7- de	mys.
	Examiner			Due to (or as	. 1	,	Heart	Disease)			10 1	
		er	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	C New s a conseq		LTCOLL	12136036				10 0	175
	ansit and	Examin	Cause (Disease or injury that initiated events	c Co	rona	P41	Artem	0:5800	SE.			20	lears
ó	be executed sician and burial-transit	Еха	resulting in death) Last	Due to (or as	s a conseq	uence of):	1						
8760	death certificate be executer e attending physician and ad for use as the burial-trans	dlcai		d									
99	rtifica ng ph as ti		IF FEMALE:										
Вох	leath certific attending p	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Feta	Ideath 3□	Ectopic pregna	incy		23	3d. Date of delive Month	ery Day	Year
0	e dea	SICI	1 Yes 2 No	4□Pregnant a 9□Unknown	at time of d	eath 5	Other (specify)			MOTE	Day	, oai
<u>Ч</u>	The law requires that the de ste has been signed by the bage 2 should be detached	Physician/Me	Part II. Other significant conditions c	ontributing to death	but not res	ulting in the u	nderhing cause	green in Part I	23e Did to	hacco us	e contribute to t	he cause of	death?
Š,	ires ti signe d be d	b y	Tan II. Other significant conditions	ontined and to doute	Datinotius	aking in the a	nderlying cause	givoir air i		es 2			Unknown
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3ec	as S	ld II							24a. Was a autops perform	SV	24b. Were auto prior to co death?	mpletion of	cause of
a	r. Th icate								1 ☐ Yes	2 No	1 ☐ Yes	2 No	
≝	icier certif ector	Be	25. Was case referred to medical examiner?	Hospital:				Other	eath (Check only on				
o	Physicien: rthis certific ral director,	၉	1 Yes 2 No 27. Manner of Death	1 Ainpat		ER/Outpatier 28b. Time o	IL SEL DOA	4 Nursing	Home 5 ☐ Reside			5 y)	
Division of Vital Records,	ding h. After fune	for	1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D.	ay Year)	Injury		njury at Work? I □ Yes 2 □ No	Ess. Busines III	ow injury	00001100		
S	Attending or death. ector: After by the fune	flca	3 Suicide 6 Could not be	28e. Place of Ir	njury - At he	ome, farm, str			28f. Location (St	treet and	Number or Rura	al Route Nu	n <i>ber</i> ,
<u>></u>	after Direct	Certification:	4 Homicide	building, e	itc." (Specif	y)			City or Town	n, State)			
	Hospital 24 hours a Funeral		29a. Certifier 1 Certifying Ph	ysician: To the bes	t of my kno	wledge, deat	n occurred at the	e time, date and plac	ce, and due to the c	ause(s) a	ind manner as s	tated.	
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examone)	niner: On the basis and manner s	of examina tated.	tion and/or in	vestigation, in m	ny opinion, death occ	curred at the time, d	ate and p	place, and due t	o the cause	s)
	To the vithin 2 To the complet	Σ	29b. Signature and title of certifier	^	1 1		-	ense number			signed (Month,	Day, Year)	
			Maria	/	1.J.		K	ES-00	0	JUN	E 22,	200	06
	\mathcal{G}_{I}		11 1	completed cause of	, A		Print)	Street.	Q.11,		M. 1	1 0	207
	1		31. Date filed (Month, Day, Year)	7	O No		Nelze.	Sarest	Daltimo	ut.	lary low	ill d	484
	Sta	ite	IAA. A	000	5 Olgi10		1						

DHMH 17 Rev 1/2001

JUN 3 0 2006 | Blesses & Joseph

ORIGINAL

Ja'niya Ebony Williams

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar		e of Death		eg. No. 200	6 206
Physiciar Medical Examin	n/	Decedent's Name (First, Middle, Last)		ra: 13 :	2. Date of Dea Month June 23, 2		3. Time of Death 1457 hrs
nedicai Examino		Ja 'Niya Ebony 4a. Facility Name (if not institution, give street and number)		Williams 4b. City, Town, or Location		2006 4c. County of Death	1457 Hrs
	ı	Johns Hopkins Hospital		Baltimore City	5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5	NA	
Funeral	7	5. Social Security Number 6. Sex 7. Age	(In yrs. last birtho			th(MM/DD/YYYY) 9. Birth	
Director	- 1	216-61-1139 1_M 2XF	4	Yrs. Months Days Hours	7-1:	2-01 Foreign	ntry) Md.
8	F	Usual Residence of Decedent 10a. State 10b. County	IOc. City, Town or	Location			10d Inside City Limits
iow an		Md. NA	•	Ltimore			1 X Yes 2 No
Aaryland 28a-f show any 1 at once.	Director	10e. Street and Number		10f. Zip Code	11	Og. Citizen of What Coun	
th the Ma 23a or 28 notified		212 S. Herring Ct.		21231		USA	
ms 23a be noti	ᇣ	11. Marital Status 12. Was Decedent E Armed Forces?	ever in U.S. 1	Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican		- 14. Race - Americ White, etc.	an Indian, Black,
r death or ite	氲	1 Yes 2	₹ No		, Fuerto Ricari, etc.)		
rs afte ural",	ھ	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade company)		1 Yes 2 X No specify:	kind of work done	Specify: B] 16b. Kind of Business/In	ack
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5-	du	ring most of working life. DO NOT			dustry
5-0036 led within 72 hou dygiene. other than "nat	ᇍ	Student		Student		NA	
15-0 Tiled w Hygie d othe		17. Father's Name (First, Middle, Last)	illiams	18. Mother	's Name (First, Middle, M Joy	Maiden Surname) Eaddy	
127 Id be if Mental marke event	o Be	John W: 19a Informant's Name/Relationship (Type, Print)		Mailing Address (Street and Nur	-	_	Zin Code\
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other transmatic event, the Medical Examiner must be notified at once	-	Joy Eaddy Mother		2 S. Herring Ct			
Fe, Fand I and Tealt Healt Fitem	Ī	20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State		Disposition (Name of cemetery, or other place)	Date	20c. Location - City or T	own, State
Pages nent o	A	Donation 5 Other Specify	~	g Mem. Pk.	6-29-06	Randallsto	wn, Md.
Baltimore, permit Pages I an Department of Hea Important: If itea injury or other tr	([21 Signature of Funeral Service Licensee)	22. Name and Address of Facility March F.H.		altimore, Mc Ol E. North	21202
Physician	-}	Page Part I. Enter the disease, or complications that object to	he death. Do not e				Approximate Interval
/Medical		failure. List only one cause on each line.		, 3.	, ,	,	Between Onset and Death
Examiner	И	Immediate Cause (Final disease or condition resulting in death) a. Blunt Force Injur					
Same of	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consec	ruence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated					
Ist Wed	EX	events resulting in death) Last Due to (or as a consect	quence of).			-	
executed an and all - transit	<u>[</u>	UNPENDED AMENDED					-
760, Icate be physical the buri		IF FEMALE: 23c. If yes, outcom	e of pregnancy			23d. Date of delivery	
687 certific dring p		23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at t	2 [Fetal death 3 Ectopia	pregnancy	Month Da	y Year
Box 68's death certiff. the attending defor use as	Physiciar	1 Yes 2 No 9 Unknown 9 Unknown	ime or death 5	Other (Specify)		1	
ords, P.O. Box 68 w requires that the death certif s been signed by the attending should be deteched for use as		Part II. Other significant conditions contributing to death	but not resulting i	n the underlying cause given in Pa	art I. 23e Did to	bacco use contribute to the	ne cause of death?
ires the signe	힣				1 Yes	2 No 3 Proba	bly 4 Unknown
ords w requas been	et				24a Wasa autop	sy prior to co	ppsy findings available mpletion of cause of
Rec The la icate h	Completed				perfor		2 No
ician: certifi rector,	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatier		26 Place of Death			
n of Vi	유	1 Yes 2 No 1 Impatier 27. Manner of Death 28a. Date of Injur		ne of Injury 28c. Injury at Work		Residence 6 Other:	
Division of Vital Records, tat or Attending Physician: The law requirers after death. al Director: After this certificate has been so the timeral director, page 2 should be the funeral director, page 2 should be the funeral director.	틸	1 Natural 5 Pending Jun 21, 2006	1305 h	ırs 1 Yes 2 ✓	Subject hear		, !
vision Attender de Directe in by t	ijg	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Inju	ıry - At home, farn	n, street, factory, office building, et		Street and Number or Rura	I Route Number, City
Divis spital or At tours after deral Direc	Certification:	4 Homicide determined (Specify) Tow	nhouse / Rov	house	or Town, S 2908 Goody	vood Road , Baltimo	ore , MD
~		29a. Certifier 1 Certifying Physician: To the best of my $Q(e)$ Q Medical Examiner: On the basis of exam					
To T To com	Medical	and manner stated 29b/ Signature and title/of certifier		29c. License number		29d. Date signed (Mont	
		((Sto lo Iny)		O.C.M.E.		June 24, 2006	
2	-	30. Name and address of person who completed cause of de	ath (Item 23a)			<u> </u>	
4	- 1	Laron Locke MD. Assistant Medical Exa	miner 111	Penn Street, Baltimore, M	D 21201		
				- Onn Otroot, Pattimore, III			
Sta Registr	L.	31. Date filed (Month, Day, Year) 32. Resistrar	s Signature	Least 1	4"		

		1	For State	State	of Marylan			t of Hea e of De			giene Reg. No.2	20603
. 8	3-1-1	7.5	Registrar 1. Decedent's Name (First, Middle)	e, Last)						2. Date of Dea	ath	3. Time of Death
	Physicia	an	,		Mary A.	Water	cs			Month 6	22 2006	11 10 M
er .	/Medic Examin	_	4a. Facility Name (If not institution	n, give street and n	umber)		4b. City,	Town, or Loc	ation of Death		4c. County of De	
758	- Au	%	2525 Eutaw 1	Place				alto				
* 8	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. 57		If Under Months		Under 24 Hrs. ours Min.	8. Date of Birt (Month, Da		Birthplace (State or Foreign Country)
1	Director		215-52-2892	X - X	37	Yrs.				8-8-	1948	Md
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	Maryl f sho	ō	Md	N/A	Ва	1to						Y Yes 2 □ No
	28a	Director	10e. Street and Number				10f. Zij	Code			10g. Citizen of What	Country?
	72 hours after death with the Maryland natural; or Items 23e or 28e-f show dical Executive round be notified.	o ie	2525 Eutaw Pi	lace				21217			USA	
	deat ms 3	ner	11, Marital Status	12. Was De	cedent Ever in U Forces?	.S. 13.	Was Dece	dent of Hispar cify Cuban, N	nic Origin? (Sp lexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - A Black, W	merican Indian, hite, etc.
9	or Its	Fu	1 Never Married 2 Mar	ned 1 Tyes	aive X No		1 🗆 Yes	37	pecify:		Specify:	Black
21215-0036	ural',	Completed by Funeral	3 ☐ Widowed 4 ☐ Divorced		Dates:	162 Door	dont's Heu	al Occupation			16b. Kind of Busine	ss/Industry
5-	-	iete	(Specify only highe			(Give	kind of wo	ork done durin ise retired)	ng most of wor	king		e Building
12	within ene. then	шc	Elementary/Secondary (0-12) 12th grade	College 2	years	(Chef				Equipment	
0	be filed within 72 hours after death with the Marylan ital Hygiene. Idea Hygiene. Idea other than *natural; or Items 23a or 28a-f show event, the Madical Executive must be notified at	BeC	17. Father's Name (First, Middle,	Last)		1		18.	Mother's Nam	e (First, Middle,	Maiden Sumame)	
lan	should be and Mentail s marked o	To B	Raymond Taylo	r]	Lilliar	Frank		
Maryland	permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than enty injury or other fraumatic event, Itel Mance.		19a. Informant's Name/Relation				•				er, City or Town, Stat	e, Zip Code)
	and 2 ealth a n 27 ls		James Waters	- Husband				an Ct	Randal		Md 21133	
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 TRemoval fro		Place of Disp cemetery, cre	osition (Na imatory or	me of other place)		Date	20c. Location - City	
Ĕ	Pages ment of I ent: If to		4 ☐ Donation 5 ☐ Other (Specify)	Me	etro C			6-30-		Catonsvi	lle, Md
Baltimore,	permit. Departr Import. eny inju		21. Signature of Funeral Service	Licensee		. 2	2. Name a	nd Address of		March F/		1 21215
	40 F • a		23a. Part1. Enter the disease, of	2 cem	t soused the deal	th. Do not or	tor the mo				Balto, M	Approximate Interval Between
			shock, or heart failure. Lis	t only one cause of	each line.	un. Do not of		30 0. 0,g, o				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	4IDI	aucasa of):						
	Examiner			Due	to (or as a consec	querice or).						
- ts	Ž.	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due	to (or as a consec	quence of):						
	ansit d	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1								
o î	be executed ician and burial-transit	Exa	resulting in death) Last	Due	to (or as a consec	quence of):						
8760	ste be executed only sician and the burial-transit	ical		d								
9			IF FEMALE:									
Вох	eath certifi attending I for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Liv	outcome of pregn e birth 2 ☐ Fet	al death 3	□Ectopic				23d. Date of Month	delivery Day Year
	0 0	sici	1 Yes 2 10	4□ Pre 9□ Un	egnant at time of a known	death 5	Other (s	pecify)				
P.0	± ≥ 5		Part II. Other significant condit	tions contributing to	death but not re	sulting in the	underlying	cause given i	n Part I.	23e. Did	tobacco use contribut	te to the cause of death?
ds,	S C 0	d by	Tarris distribution of the state of the stat	3		•	- , 3			10	Yes 2.□No 3	Probably 4 Unknown
ecords,		Completed								24a. Was	an 24b. Were	e autopsy findings available
Rec	e la has	mp								auto perfe	psy prior deat	to completion of cause of h?
<u></u>	certificate	e Co	25. Was case referred to medic	al				26	6 Place of De	1 Yes		Yes 2 No
Vital	Physicien: this certific al director,	To Be	examiner?	Hospital:	☐ Inpatient 2 ☐	☐ ER/Outpation	ent 3 🗆 🗅	Other			idence 6 Other (Specify)
Division of		E E	27. Manner of Death	28a. Da	ite of Injury fonth, Day Year)	28b. Time Injury	of	28c. Injury at Work?		28d. Describe	how injury occurred	
ion	별근돌호	atio	Z [ACCIDENT	tigation	,,,	,,	М		s 2 No			
<u>×is</u>	r Atte er de recto by th	Certification:	3 Suicide 6 Coul	missed 200, FR	ace of Injury - At I	home, farm, s	street, facto	ry, office		28f. Location (City or To	(Street and Number o wn, State)	or Rural Route Number,
Ö	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the											
	Hospital 14 hours 2 Funeral 1 tely filled	edicai	(Check only 2 Medica	al Examiner: On th	e basis of examin	nowledge, de: nation and/or	ath occurre investigation	d at the time, on, in my opini	date and place ion, death occi	e, and due to the urred at the time	cause(s) and manne , date and place, and	or as stated. due to the cause(s)
	To the h within 24 To the F complete	Med	one) 29b. Signature and title of certifications		nanner stated.		2	9c. License n	umber		29d. Date signed (N	fonth, Day, Year)
	To Vit		255. Orginators and into or certific			,						
			30. Name and address of person	7 /2/	ausa of death fits	M 23a) (Tuo	e Print\	V 36	373		JUNE	26,2006
	3		30. Name and address of person	Be (Ced)		Luaj (+ypi	BI	148	1010/1	1111	7/9/14	
20	S	ate	31. Date filed (Month, Ua) Yes	7) n 200c 32		alure	79-	9	10/1	417		
	Regis		JON	0 2000	RELIEVE	15	GORN	2)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMND THE #6, per FIL 0857, 7/21/06, WS
State of Maryland / Department of Health and Mental Hygiene) | | | | |

20694 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 929 M UNE 12 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner med O undel If Under 1 Year If Under 24 Hrs. Truno Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 10 M 25 untry) NJ 148-14-8807 81 Director 02/27/1925 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or itame 23a or 28e-1 show 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits "natural", or itame 23a or 28e-f shov dical Examiner must be notified at Pinellas Palm Harbor FL 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34684 1642 E. Dorchester Ct. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 □ No If Yes, Give Year or Dates: 1943-46 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) treumatic event, I've Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 12 New Jersev Bell 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Max Paul Wittig ٥ Hedwig Johanna Meeh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara W. Palumbo (Daughter) item 27 i other tre 12 Julianne Way Randolph, NJ 07869 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Importent: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 6/30/06 Baltimore, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) Gary L. Kaufman Funeral Home at MMP, 7250 Washington Blvd. Elkridge, MD 21. Signature of Funeral Service Licensee Elkridge, MD 21075 art1. Enter the disease or companions shock, or heart failure. List only or that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Trteriosclero Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 **N**o 1 🗆 Yes Division of Vital To the Hospital or Attending Physicien: 25. Was case referred to medical examiner?
1 A Yes 2 □ No funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation s effer dea. 1 Natural 1 □ Yes 2 □ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours e To the Funerel C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Direction Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier and manner stated 29b. Signature and title of certifier eputy 29d. Date signed (Month, Day, Year) 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jones mo . Registrar's Sign 31. Date filed (Month, Day, Year) State JUN 3 0 2006 a Super Registrar

		4	For Amend Items 2	State of Maryla 23b, 25, 27, 28	and / Depa a-f per	artment of H	ealth and N 96/29/060	lental Hyg lhb	giene Reg. No.	006	20695
	WE.		Decedent's Name (First, Middle, Last)					2. Data of Dea Month	ith Day	Year 3.	. Time of Death
	Physicia	_	Soung Kak Yang					March	26,2		THO PM
)	/Medic Examin	ai -	ta. Facility Name (If not institution, give	street and number)			Location of Death		4c. Count		
			Union Memorial Hos			Balt If Under 1 Year	inore If Under 24 Hrs.	Date of Birth	h	N/A	/Ctoto or Foreign
	Funeral		5. Social Security Number 6. Sec	TN 000	rs. last birthday) 32 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day May 02,	1923	Seoul,	(State or Foreign Korcea
	Director		214-23-9743 Usual Residence of Decedent)	l		ray oz,	1923	500017	
	/land		10a. State 10b. County	10c.	City, Town or L	ocation					Inside City Limits
	Man	tor	Maryland N/A	. E	3altimor	e					1 ☐Yes 2 ☐ No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?	(
	23e		11 West 20th Stree				.218			ed Stat	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It has the marked of the than "neture!", or Items 23e or 28e-f ehow them 27 ie marked other than "neture!", or Items 23e or 28e-f ehow other traumatic event, the Macical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2€Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates:	n U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ŽŽÍNo	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	1	ce - American i ack, White, etc. ^{fy:} Korea	
21215-0036	ture!	edt	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation		16b. Kind of E	Business/Indust	iry
215	nin 72	Completed	(Specify only highest grad	completed) Cotlege (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of won ()	ang			
212	filed within Hygiene. Sther then "	E O	12	N/A		Cashier				Young M	arket
밀	al Hygin d other	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	, ,	Maiden Suma	me)	
yla	should be and Mental and Mental and Mental and marked o	၉	Eun Suk Yang	0.1.0	405-14-11	ing Address (Street	Sung Bu		City of Tour	State Zin Co.	dol
Maryland	12 sho		19a. Informant's Name/Relationship (T)			Abel Str				_	
	1 and 1 Health tem 27		Mrs. Hwa Lee (Daug 20a. Method of Disposition		b. Place of Disp	osition (Name of	1	Date	-	- City or Town,	
บดู			1 ☑Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			matory or other place Valley Meri		ch 29,	Timoni	um,Mary	land
Baltimore,	perrit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens		Gair, Sr	eaceful A	Mternati Road Ti	ves Fune monium,	eral&Cr	emation	Ctr.,P.A
	Physician		23a. Part Erter he disease for component of heart failure. History of the disease or condition resulting in death)	· Subdura	death. Do not en					Ap Int	pproximate terval Between nset and Death
	/Medical Examiner		resuming in death)	Due to (or as a cor	isequence of):	F-1 - 1 - 2		1.4	,	3	1
		Je.	Sequentially list apportions if any, leading to immediate	b. Due to (or as a cor	sequence of):	TE POET TO	-3C	1//	1//		++1.Y-2
	ate be executed obysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c			-0.	APPROVED BY M	EDICAL EXAMIN	ER	
ó,	certificate be executed nding physician and use as the burial-transit	Ex	resulting in death) Last	Due to (or as a cor	sequence of):		THE TION	APPROVED BY			
8760,	ate be hysici ihe bu	lical		d			CEKIII.			-	
9	e as (Med	IF FEMALE:	02a Musa sutasma of as	oananou				004.0	one of delicer	
P.O. Box	death e atter id for u	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. tf yes, outcome of pro 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	′			ate of delivery fonth Da	y Year
	s that the ned by th e detache	by Pl	Part II. Other significant conditions co	ontributing to death but no	t resulting in the	underlying cause giv	en in Part I.		obacco use co		
ğ	requires een sign rould be	ed						10,	Yes 2127No	3 Probabt	y 4 □Unknown
of Vital Records,	e lar has	Completed						24a. Was autor perfo		. Were autopsy prior to compt death?	findings available letion of cause of
ita	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?	-172		l ou		ath (Check only o	one)		
7	G 5. X	2	1 LAYes 2 19 NO		2 ER/Outpation		- I recoming t	ome 5 Resident			
n c	nding Path. r: After e funera	lon	27. Manner of Death Continue	28a. Date of Injury (Month, Day Yea 03/24/2006	ar) 285. 11me Injury 5:00	Wo	rk? Yes 2 X No		ct fell		
isio	Attender death	licat	3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm, s	treet, factory, office		28f. Location (Street and Nun	nber or Rural R	oute Number,
Division	after Direct	Certification:	4 Homicide determined	building, etc. (S) Street	pecify)	,,		E 22nd	& N. C	harles	St.,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	ysician: To the best of my ninar: On the basis of exa and manner stated.	knowledge, dea mination and/or	ath occurred at the tri investigation, in my o	me, date and place opinion, death occu	Baltime, and due to the arred at the time,	cause(s) and r	manner as state a, and due to th	id. e cause(s)
	To the within To the compli	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sign	ned (Month, Day	y, Year)
			I ham So New	Jhon, M.D.	(ltom 02=) T	AT 24	38946	1	March !	28,2	006
			30. Name and address of person who	phill. M.D	· U		notial	Hospital	MI)	
		ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	- 40	-				
	Regis	trar	JUN 2 9 200	5 filesure	Dr. Agos	ua.					

ORIGINAL

		4	For State Registrar	State of Ma	aryland		artment of H			R	eg. No. C	06	20(696
: ' ;	Physicia		1. Decedent's Name (First, Middle,	Thomas A.	Zing	one				2. Date of Dea Month June	Day	Year 006	3. Time of 8:35	Death A M
	/Medic Examin	A	4a. Facility Name (If not institution, Suburban Hospit				4b. City, Town, or Bethese				4c. County			
	Funeral Director		074-30-6154	Sex 7. Age 1 ⊠ M 2 □ F	76	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2	Min.	8. Date of Birth (Month, Day Jan. 1,	1930	9. Birth Cou New	olace (State of ntry) York	r Foreign
	Maryland show		Usual Residence of Decedent 10a. State 10b. County Maryland Montgo	mery	10c. City,	Town or Lo	cation Rockville						10d. Inside Cil 1 ☐ Yes	
	with the	Director	10e. Street and Number 10728 Brewer Ho	use Road			10f. Zip Code	.0852			10g. Citizen of United			
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent, the Medical Examinat must be indifficat at ance.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? d 1 🔀 Yes 2 🗆 N If Yes, Give Year or Dates:	40		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin, Mexican,	jin? (Spec , Puerto F	cify Yes or No- Rican, etc.)	Bla	ce - Ameri ick, White, fy: Wh:		
Maryland 21215-0036	within 72 hou ene. than "nature	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	i+)	(Give	dent's Usual Occup kind of work done DO NOT use retired tronics T	during most d)		g	16b. Kind of E		ndustry	
land 2	uld be filed Mental Hygi irked other ific event,	To Be Co	17. Father's Name (First, Middle, L Frank Zingone					Jos	seph	(First, Middle, ine Ros	ano			
Mary	nd 2 sho Ith and I 27 le ma		19a. Informant's Name/Relationsh Mildred Zingone				ng Address (Street Brewer H							5 2
Baltimore,	Pages 1 ar		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp	3 □Removal from State	Mon	metery, crei	sition (Name of matory or other place y Inc.	ce) .	June -2006		20c. Location Betheso			đ
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service L	~	M001	98 R 75	Name and Address bert A. 57 Wiscon	ss of Facility Pumphi sin Av	rey l	Funeral Sethesda	Home/ ^I MD 2	Bethe Cha 0814-		
760,	Physician /Medical Examiner sthe pnrian-transit	ical Examiner	23a. Part1. Effer the disease, or o shock, or heart failure. List of shock, or heart failure. List of disease or condition resulting in death) Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	nly one cause on each li	ne. Iyoca1 a consequ	rdial ence of):	Infarcti		cardiac o	respiratory ar	rest,]	Approximation interest and I hour	ween
.O. Box 68	ne death certifics the attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ∐Live birth 4 ∐Pregnant a 9 ☐ Unknown	2 Fetal	death 3	□Ectopic pregnanc □ Other (specify) _	y				ate of deliv		Year
<u>α</u>	sign d be	by	Part II. Other significant condition Multiple Myelor	•	out not resu	elting in the c	inderlying cause gr	ven in Part I.		23e. Did to	obacco use cor ∕es 2⊠No		the cause of dibably 4 🗆	
I Records,		Completed								24a. Was autop perfo 1 Yes	rmed?	. Were aut prior to c death? 1 Yes	opsy findings ompletion of c 2 No	available ause of
Vital	Physician: this certific al director,	o Be	25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No	Hospital:	ent 2.1XII	ER/Outpatie	nt 3□ DOA Ott	SAF		Check on lo		ther (Spec	ity)	
Division of	ding h. After funer	Certification: T	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could n	28a. Date of Inju (Month, Da	ury ly Year)	28b. Time of Injury	of 28c. Inju Wo M 1	ry at rk?]Yes 2 □N	No	28d. Describe h			rat Pauta Num	, hor
Divi	tal or Attenis after deat al Director:	Certifi	4 Homicide determi		tc. (Specify)	reet, factory, office		4	City or Tov		iber or ribi	ar riodia riodi	1067,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filted in b	edical	29a. Certifier 1 🔀 Certifyin (Check only one)	g Physician: To the best examiner: On the basis of and mayner st	of examinat	wledge, dea tion and/or in	nvestigation, in my	opinion, deal	d place, a	ed at the time,	date and place	, and due	to the cause(s	3)
	To the within 2 To the comple	Σ	29b. Signature and title of conflict	Kores	L		29c. Licen	9834			29d. Date sign			
	1241		30. Name and address of person Barry Rosenbaum				Avenue,	Kensi	ngtoi	n, Mary	land 20	0895		
	St Regist	ate trar	31. Date filed (Month, Day, Year) JUN 3 0 20		rar's Signa	-	W.							

			For State Registrar	State of I	Maryland /		artment <i>tificate</i>			nd Me	entai Hy	/gien Reg. N	6-	106	20697
	Physici		1. Decedent's Name (First, Middle, L Pat Morphia And	derson							2. Date of D Month りょん	eath D	ay So	Year 2006	3. Time of Death
Y	/Medic Examir		4a. Facility Name (If not institution, gi		9r)		4b. City, 1	Fown, or	r Location of	Death	33710			y of Death	117
		•	Union Memorial Ho	ospital			Bal ⁻	timo	ore						
	Funeral Director		5. Social Security Number 6. 268–32–0177	Sex 7. 1 □ M 2 ☑ F	Age (In yrs. last bi 72	irthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	8. Date of 8 (Month, D	irth lay, Year 7 , 19.	33	9. Birthpl Count Ohio	ace (State or Foreign rry)
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Lo	cation							10	Od. Inside City Limits
	Manyla f eho	ō	Maryland Baltim	oro	Middle									'	1 ☐ Yes 2 ☑ No
	r 28s	irec	10e. Street and Number	ле	MICCLE	: III	10f. Zip	Code				10g. C	itizen of	What Count	try?
	th wit	alD	3715 Holly Grove	Road				212	220			U.S.	.A.		
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow applications of the traumatic event, the Medical Exactions can be notified at ance.	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	s? ZXo		Vas Decede f Yes, speci I ☐ Yes 2		ispanic Origi n, Mexican, Specify:	n? (Spec Puerto R	cify Yes or N lican, etc.)	0-		ce - America ick, White, e	
21215-0036	thin 72 hou e. an "nature Medical E	Be Completed	15. Decedent's financial (Specify only highest given the secondary (0-12)			(Give	lent's Usual kind of work DO NOT use	k done d	durina most d	of workin	g	16b.	Kind of E	Business/Ind	
2	led wi	Co	17. Father's Name (First, Middle, Las	2		Home	emake:	r	10 14-15-4	- NI	/51 A 41-d-44		vn H		
and	d be findal H	Be	Gust Mavergeorge	t)							(First, Middle		n Sumai	me)	
Maryland	shouk nd Me mark imatic	2	19a. Informant's Name/Relationship	(Type, Print)	191	b. Mailin	g Address	(Street a	LEHOI and Number		Pulinc		or Town	State, Zip	Code)
Z	and 2 alth a 27 is		Emanuel Anderson	(Husband	37	715 I	Holly	Gro	ve Roa	ad, 1	Baltim	ore	, Ma:	ryland	1 21220
Baltimore,	of He of He of item		20a. Method of Disposition ★○ **Burial 2 ☐ Cremation 3	Removal from Sta	20b. Place o	of Dispos	sition (Nam natory or oti	e of her plac	e)	Da	ite	20c. l	ocation	- City or Tov	vn, State
ij	ment tant: tant:		4 □ Donation 5 □ Other (Spec	i(v)											Maryland
Bai	Depermit Deper Impor eny in		21. Signature of Funeral Source Lie	Acoo.		22	. Name and	Addes	użdziy	nski	Funer	al F	1ome	, P.A.	
			23a. Part1 mer the disease, or con	nplications that caus	sed the death. Do								sex,		and 21221 Approximate Interval Between
)	Physician /Medical		sho, or heart failure. List only immediate and including in death)	a Pa	tent F	sec	men	0	rale						Interval Between Onset and Death
	Examiner	_	Sequentially list conditions,	b. Mi	as a consequence	Lre	Pr	clas	ose						2040
Т	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		CUSPA) 1	1	re f	2001	apse						201,05
ó	ficate be executed physicien and Es. the burial-transit	Еха	resulting in death) Last		as a consequence										- Y/J
8760,	ate be hysici the bu	dical		d											
9	entific ding p	Med	IF FEMALE:	23c. If yes, outcome	no of programmy										
P.O. Box	The law requires that the death certif ete has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth	2 Fetal death at time of death		Ectopic pre Other (spe							ate of deliver onth I	y Day Year
	s that gned b	by PI	Part II. Other significant conditions		but not resulting	_		iuse give	en in Part I.		23e. Did	tobacco	use con	tribute to the	cause of death?
Zg	w require been sig should b	ted	Liver failu	re lead	ing to	R	enal	tai	lure		10	Yes 2	2 □ No	3 🗌 Proba	ably 4 Munknown
I Reco	The law r te has be age 2 sh	Completed						-			24a. Was auto perf 1 Yes			death?	sy findings available ipletion of cause of
Vita	, bior		25. Was case referred to medical					0#		of Death	(Check only	_			
	iclan: certifice ector, p	Be	examiner?	Hospital:		utactions		A Othe	Br. A Nure	ing Hom	a 5 - Dan	idence	6 101	/0 4	
ō	Physician: ' r this certifice ral director, p	To Be	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Minp.							e 5 Res)
on of	nding Physician: ' uth. :: After this certifice e funeral director, p	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of I	njury 28b.	Time of Injury		Bc. Injury Work		28	3d. Describe)
Division of Vital Records,	ai or Attanding Physician: 's effer death.'s effer this certifice at Director: Affer this certifice at in by the funeral director, p	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of I (Month,	njury 28b.	Time of Injury	M 28	Bc. Injury Work	/ at </td <td>0 28</td> <td>3d. Describe</td> <td>how inju</td> <td>ny occui</td> <td>red</td> <td>Route Number,</td>	0 28	3d. Describe	how inju	ny occui	red	Route Number,
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			1 - For Stata Registrar	State of Maryland		nt of Health a te of Death	nd Mental F	Hygiene Reg. No:-	006	20698
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, La DAVID . B. 4a. Facility Name (If not institution, given to the control of the control	ARMSTRONG	4b. Cit	y, Town, or Location of		28 Day	Year 2006 County of Death	3. Time of Death 5.7.17 A M
放	Funeral Director			Sex 7. Age (In yrs. Ia	Yrs. If Und Month	er 1 Year If Under 2		Birth Day, Year)	Cou	place (State or Foreign ntry) MD
	h the Marylan or 28a-f show	irector	10a. State 10b. County 10e. Street and Number	IA .	Town or Location BA 10f. 2	It I Make		10g. Citiz	en of What Cou	10d. Inside City Limits 1 → Yes 2 □ No ntry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 Is marked other than "naturel", or Itama 23s or 28s-f show other traumatic event, the Medical Examiner must be natified at	by Funeral Director	6 1 5 . E . 3 8 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1	If Yes, sp	edent of Hispanic Orig ecity Cuban, Mexican, 2 DNo Specify:	in? (Specify Yes or Puerto Rican, etc.)		4. Race - Americ Black, White,	can Indian,
121215-0036	filed within 72 ho Hygiene. Ather than "nature ent, I've Medical I	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	vork done during most use retired) UNLIA		50	d of Business/In	,
Maryland	2 should be fi and Mental H Is marked of surnatic ever	To Be	17. Father's Name (First, Middle, Last G-LORGE ARIN 57 19a. Informant's Name/Relationship	Rong SR Type, Print)	19b. Mailing Addre		093	K o-eT	Town, State, Zip	
Baltimore, N	0 0 == =		20a. Method of Disposition 1 Surial 2 Cremation 3 [4 Donation 5 Other (Speci	20b. Pla	ace of Disposition (N metery, crematory or AD TWC IA	ame of other place)	Date 1/1/66	20c. Loc	ation - City or To	
Balti	permit. Pag Department Important: I any injury o		21. Signatura of Funeral Service Lice Paul M 23a. Part 1. Enter the disease, or com	Stella	PAUL 753		UNERAL F RD. BAL	tome, of		
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	cer	oue or dying, such as c	ardiac or respirator	y allest,		Interval Between Onset and Death
8760,		ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b						
P.O. Box 68	The law requires that the death certificate be executed The has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3 Ectopic			23	d. Date of delive	ery Day Year
Records, P	w requires that been signed t should be deta	þ	Part II. Dther significent conditions of	contributing to death but not result	ting in the underlying	cause given in Part I.		d tobacco use		ne cause of death? bebly 4 []Unknown
Vital Rec		3e Completed	25. Was case referred to medical			26. Place o		rformed?	24b. Were auto prior to cor death? 1 \(\sum \text{Yes} \)	psy findings available mpletion of cause of
of	ling Phys I. After this funeral di	ation: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	R/Outpatient 3 C 28b. Time of Injury M	Other	sing Home 5 Re 28d. Describ			(Y)
Division	Hospital or Attence 4 hours after death Funeral Director: itely filled in by the it	ai Certification:	3 Suicide 4 Could not be determined	building, etc. (Specify)	ledge death occurre	d at the time, date and	City or 1	Town, State)	nd magazir as at	If Route Number,
)	To the Hospital or A within 24 hours after To the Funeral Direction completely filled in b	Medical	(Check only 2 Medical Example) 29b. Signature and title of certified	niner: On the basis of examination and manner stated. DIRECTOR, MEDICAL DU	on and/or investigation	n, in my opinion, death	MD occurred at the tim	e, date and p	signed (Month,	Day, Year)
	Ŋ		30. Name and address of person who Tohus Hophins Hospi	completed cause of death (Item	33a) (Type, Print)	, Balti	more,	MN	2128	
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Régistrar's Signatu	& Speed		•			

State of Maryland / Department of Health and Mental Hygiene 20699 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 2, Physician Year 2006 Diana Barbarino 1:55 РΜ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1025 Hewitt Way Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2121€ 54 Director 218-58-3749 15,1952 West Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If Item 27 is marked other then "neturel", or itema 23a or 28a-1 ehow any or other tranmal be notified at my or other tranmals. 10a. State 10b. County 10c. City, Town or Location il Hygiene. other then "naturel", or itema 23a or 28a-1 ehow vent, the Medical Examinar must be notified at 10d. Inside City Limits Completed by Funeral Director XXYes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1025 Hewitt Way 21205 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritaf Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 2 ☐ No If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 Yes 20XNo Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Billing Clerk Shoe Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earnest Walker ဂ္ Hazel Bishop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1004 Hewitt Way, Baltimore, Maryland 21205 Paula Burke (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. Holly Hill Mem. Gard. July 6,2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Provision Inchese 22. Name and Address of Eacility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) **Physician** Neuroandocrine 5 years Pancreas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Pureral Director: After this certificate has been signed by the attending physician and completely filled in by the funderal director, page 2 should be detached for use as the burnar-transit Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) Hospitaf: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DØØ57802 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 401 North Broadway Baltimore, Maryland Wells Messersmith 31. Date filed (Month, Day, Year) 32 degistrar's Signature State JUL 0 3 2006 Registrar

			1 - For State Registrar	State of Marylan		artment of H rtificate of			giene Reg. No.	06 20700
	Physici /Medi		Decedent's Name (First, Middle, Last) JAMES EDMUND	BRADY JR				2. Date of Dea	_	3. Time of Death 5:37P M
).	Examir		4a. Facility Name (If not institution, give s 223 East Norther			4b. City, Town, o	r Location of Deat	h	4c. County of N/	
	Funeral Director			7. Age (In yrs. 67	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1939	9. Birthplace (State or Foreign Country) Virginia
	Maryland e-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	a or 28	i Dire	10e. Street and Number 223 East Northern			10f. Zip Code 212 f	12		10g. Citizen of Wh	
036	should be filed within 72 hours after death with the Maryland nd Menial Hygiene. marked other than "natural", or itame 23a or 28e-f ehow imatic event, Ita Madical Examinar man La notified at	by Funeral Director		12. Was Decedent Ever in U Armed Forces? 1 ∐Yes A M No ff Yes, Give Year or Dates:	ł	_		Specify Yes or No- to Rican, etc.)		American Indian, White, etc. White
21215-0036	d within 72 ho giene. ir than "natur ithe Mudical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life. L	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo	rking	16b. Kind of Busin	ness/industry
Maryland	should be filed nd Mental Hygi marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) James Edmund Brady	Sr				me <i>(First, Middl</i> e, aret Ryan	Maiden Sumame) Berry	
Mar	es 1 and 2 should b of Health and Ment fitem 27 ie marked r other traumatic		19a. Informant's Name/Relationship (Τχ. Patricia B Surratt	Niece		•			r, City or Town, St. nd Texas	
altimore,	Peges 1 and of He		20a. Method of Disposition XXBurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	emetery, cren	sition (Name of natory or other place Cemetery		Date	20c. Location - Ci	e, Maryland
Balti	permit. Peges Depertment of Importent: If it eny injury or o		21 Signature of Fune Alsophic License				ss of Facility M	itchell-Wie	defeld Fun	eral Home Inc. yland 21212
	Physician Medical Examiner but strength of the private transit to the private transit to the private transit to the private transit to the private transit transit to the private transit tran	dicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to trained late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	MyOCardi Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq	al Infa uence of): uence of):		g, such as cardia	c or respiratory and	est,	Approximate Interval Between Onset and Death
Box 6	death certil e ettending ad for use a	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnancy	,		23d. Date of Month	
Records, P.	law requires that the de es been signed by the e 2 should be detached t	ρ	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	nderlying cause giv	en in Part I.	23e. Did to	WW	ute to the cause of death?
r	The ate h page	e Completed	25. Was case referred to medical						AUX No 1 L	re autopsy findings available or to completion of cause of hth?] Yes 2 ☐ No
ot V	Physician: rthis certific ral director,	70 B	examiner? 1 ☐ Yes XXNo		ER/Outpatient		er: 4 🗆 Nursing H	T	ence 6 Other	
Division	Affe une	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		yat k? Yes 2 ☐ No		ow injury occurred	
É	p 를 들 드		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	/)		- data c - d - l	City or Town	n, State)	or Rural Route Number,
	5 4 1 9 6 4 1 2 6	ledicai	one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wieuge, death tion and/or inv	estigation, in my o	ne, date and place pinion, death occu	e, and due to the co	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. Licens	53445	2	9d. Date signed (A	
	8		30. Name and address of person who con Tobert T Turner,	mpleted cause of death (ftem M.D. 7600 0	sler D	rive Tows	on. Mary	land 212	04	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	,	on, nuly	Tunu ZIZ	U 4	

06-04542

Please Type or Print in Black Indelible Ink

/lichael Brown		State of Maryland / Department of I	Death	2006 2070
Physici		1. Decedent's Name (First, Middle, Last)	2. Date of De Month	Day Year
Medical Exami	ner	MICHAEL	June 28, b. City, Town, or Location of Death	
		301 North High Street Apt. 220	Baltimore	NA
Funeral Director		5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) $215 - 100 - 3221 1 \times M 2 = F$ 7. Age (In yrs. last birthday) Yrs	If Under 1 Year If Under 24Hrs 8. Date of B Months Days Hours Min.	Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
-		Usual Residence of Decedent		15,113 11 11101
d 10w any		10a. State 10b County 10c City, Town or Location		10d Inside City Limits 1 Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number	More 10f. Zip Code	10g Citizen of What Country?
with the Maryland us 23a or 28a-f she be notified at once		1. 2. 1 21 1947 1110//4 9 521 1975 1	21234	USA
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U S Armed Forces? 1 Yes 2 No	Decedent of Hispanic Origin? (Specify Yes or N , specify Cuban, Mexican, Puerto Rican, etc.)	14 Race - American Indian, Black, White, etc.
s after or raff, o	þ	3 Widowed 4 Divorced if Yes, Give Year or Dates:	es 2 No specify	Specify: Black
72 hour n "nate al Exar	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Usual Occupation (Give kind of work done it of working life DO NOT use retired)	16b Kind of Business/Industry
15-0036 filed within 72 hou I Hygiene ed other than "nate t, the Medical Exa	omp	17. Fether's Name (First, Middle, Last)	Counting 18. Mother's Name (First, Middle,	Private
21 be fi rked	Be	Donell Brown	Carmelit	a Hall
○ 8 5 5 5 1	ပ္	19a. Informant's Name/Relationship (Type, Print) Sister 19b. Mailing A	Address (Street and Number or Rural Route Nu	umber, City or Town, State, Zip Code)
ore, MD strand 2 sho of Health and If item 27 is ner traumati		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other		20c. Location - City or Town, State
6 분 분 구 교.		4 Donation 5 Other Specify Garriso	n Forest 7/10/2001	Owings Mills, Md.
Balt permit Depart Import		21 Signature of Funeral Service Licensee 22. Nan JoSe	ne and Address of Facility eph L. Russ Funera	I Home, P.A.
Physician /Medical		23a Part I. Enter the disease, or complications that codsed the death. Do not enter the failure. List only one cause on each line	mode of dying, such as cardiac or respiratory an	rrest, shock, or heart Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a Seizure disorder Due to (or as a consequence of)		Death
***	er	Sequentially list conditions, b.		
	Examine	if any, leading to immediate cause. Enter Underlying Cause (cisease or injury that initiated		
executed an and al - transit		events resulting in death) Last Due to (or as a consequence of):		
60, ate be exe hysician a	Medical	xunpended	,g857,7/25/06 TT	
5876 striffcate sing phy	an/M	Dast 12 months?	death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
Box 687 death certific the attending p ed for use as the	ysician/I	4 Pregnant at time of death 5 Other 1 Yes 2 No 9 Unknown 9 Unknown	r (Specify)	
P.O. Box 68760, so that the death certificate be executed greed by the attending physician and e detached for use as the burial - transit	by Phy	Part II. Other significant conditions contributing to death but not resulting in the und		tobacco use contribute to the cause of death?
ords, P.C w requires that is been signed is			1Ye	san 24b. Were autopsy findings available
ecor ne law r te has b	Completed		auto perfc	psy prior to completion of cause of death?
Vital Rec ysician: The bis certificate lirector, page	Be Co	25. Was case referred to medical examiner?	26 Place of Death (Check only one)	2 No 1 Yes 2 No
1 of Vit ling Physic After this funeral dire	P	1 Ves 2 No Prospiration 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death 28a Date of Injury 28b Time of Injury		Residence 6 Other: Scene
ion c tending eath for: Af	ation	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	Certification:	3 Suicide 6 Could not be determined (Specific)	factory, office building, etc. 28f. Location (or Town, \$	Street and Number or Rural Route Number, City State)
Di Hospital 24 hours a Funeral I		4 Homicide (Specify) 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred	d at the time, date and place, and due to the cau	se(s) and manner as started
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated 29b, Signature and title of certifier	n, in my opinion, death occurred at the time, date	
		Osso Services	O.C.M.E.	29d. Date signed (Month, Day, Year) June 29, 2006
		30. Name and address of person who completed cause of death (item 23a)		
<u> </u>	ate	1	eet, Baltimore, MD 21201	
Regist		JUL 0 3 2006 Steam IF specific		
DHMH 17 Rev 1/20	001	ORIGINAL		

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month Amelia E. Barnett 15, 2006 5:50 PM M /Medical June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 907 Sapphire Court Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗑 F Director 149-12-1351 92 Sept 11, 1913 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MDWicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 907 Sapphire Court 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Be Completed by 3 Widowed 4 Divorced Specify: white Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Depertment of Health and Mental Hygier Important: if Item 27 is marked other th any injury or other traumatic event, Lisa once. waitress/hostess restaraunts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John L. Ruark Amelia E. Lakates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ina Rae Ruark/daughter 907 Sapphire Court Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Sinature Konald S. Wade Director State Anatomy Board 655 W. Baltimore Street 2000 Baltimore, MD 21201 23a. Part Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician non small all curanoma 6 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of). Physician/Medical Examiner I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physicien and in by the Inneatid rifector, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes 2 🛣 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Town D0014314 6107106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANPIT P. KLUG. 145 E Corroll STRET, Solisbury, M.D. 21801 31. Date filed (Month, Day, Year) 32 Registrar's Signature 0 3 2006 Registrar

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
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			1 - State Registrar	f Marylan		artment of H tificate of i	lealth and N Death		giene 0 0	6 20704
П	Physici	ian	Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
	/Medi		EVELYN E. CHASE					JUNE	29, 200	- !
	Examir	ner	4a. Facility Name (If not institution, give street and nut	mber)		4b. City, Town, or	Location of Death		4c. County of	f Death
			MANOR CARE TOWSON 5. Social Security Number 6. Sex	7. Age (In yrs. I	lage birth de	TOWSOI If Under 1 Year	If Under 24 Hrs.	10.5.		IMORE
	Funeral Director		214-14-5981 1 M 2 DXF	85	Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da	y, Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent					9/28/1	920	MARYLAND
	rylan		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Ba-f s	cto	MD BALTIMORE	Т	OWSON					1 ☐ Yes 2 XNo
	vith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?
	s 23e	Funeral Director	1643 NATURA ROAD			2128			USA	
	lter de	'n	11. Marital Status 12. Was Dece Armed Fo 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes			Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, White, etc.
21215-0036	filed within 72 hours atter death with the Maryland Hygiene. kther then "neturel", or Items 23e or 28e-1 show ant, the Medical Examinat must be rediffed at	b	3 X Widowed 4 □ Divorced If Yes, Giv Year or Divorced	/e * 1	1	☐ Yes 2∏ No	Specify:		Specify:	WHITE
ğ	2 hor	Completed	15. Decedent's Education		16a. Deced	ent's Usual Occupa	ation furing most of work		16b. Kind of Busi	
2	thin 7	ηpie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1	-4or 5+)	(Give life. L	kind of work done of OO NOT use retired	furing most of work)	ing		,
	ed wi	Con	11TH GRADE		Н	OMEMAKER			OWN HO	ME
gu	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Sumame)	
<u></u>	should be filed within and Mental Hygiene. marked other than umatic event, the Market	2	WILLIAM LAY					TINCHCO		
Maryland	d 2 th a 7 is		19a. Informant's Name/Relationship (Type, Print) DENNIS T. CHASE/SON						or, City or Town, St	ate, Zip Code)
	1 and Health tem 27		20a. Method of Disposition	20b. PI		NATURA RO		ON, MD	21286 20c. Location - Ci	hr or Town State
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1X Burial 2 ☐ Cremation 3 ☐ Removal from 5 4 ☐ Donation 5 ☐ Other (Specify)			FOREST PVI	ľr.			
<u>=</u>	permit. Page Department of Important: If any injury or once.		21. Signatur of Funeral Service Licensee		CEMET	ERY Name and Addres		2006		MILLS, MD
ñ	permi Depar Impo any ir		Heather Ha	chi			RAVEN BL		ON FUNERA WSON, MD	AL HOME, P.A. 21286
			23a. Fart. Enter the disease, or complications that can shock, or heart failure. List only one cause on ear	aused the death						Approximate
	Physician		Immediate Cause (Final							Interval Between Onset and Death
	/Medical		resulting in death)	or as a consequ	ence of):					WEEKS
	Examiner	_	Sequentially list conditions, b.							
	₩ ±	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course (Disease or in Juny)	or as a consequ	ence of):					
	s be executed sicien and burial-transit	Examiner	that initiated events c.	or as a consequ	ence of):					
98760	sicier buri				,					
9	The law requires that the death certificate be executed the has been signed by the attending physicien and sage 2 should be detached for use as the burial-transit	edicai	0.							
ROX	at the death certific by the attending patached for use as	Physician/M	200. Was decedent pregnant	come of pregnan		~			23d. Date o	of delivery
n C	ed for	sicis	1 Yes 2 No	ant at time of dea		Ectopic pregnancy Other (specify)			Month	Day Year
J.	at the	Phy	3 CHKHOWH							
Š,	res tha signed be det	by	Part II. Other significant conditions contributing to de	ath but not resul	lting in the un	derlying cause give	n in Part I.			ite to the cause of death?
Ö	w require been sig should b	eted	Dementiq					1 L Y	es 2 No 3	Probably 4 Onknown
Vital Records,	The taw cate has b page 2 s	ompieted						24a. Was a autops	sy prio	re autopsy findings available r to completion of cause of
		O	05 W					perform 1 Tes	med? deal	Yes 20 No
5	lysicien: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ In				26. Place of Death			
0	g Phy er this eral d	\vdash	27. Manner of Death 28a. Date o		28b. Time of	3 DOA	4 Yoursing Hor		ence 6 Other (Specify)
DIVISION	nding ath. r: Afte e fun	atio	1 Natural 5 Pending (Month 2 Accident investigation	n, Day Year)	Injury	28c. Injury Work' M 1 \(\sup Y	es 2 □No		or injury december	
<u> </u>	· Atte	tifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of building	of Injury - At hon	ne, farm, stree	et, factory, office	2	8f. Location (St	reet and Number of	or Rural Route Number,
5	tel or rs afte el Dir	Certification:	Buildin	g, etc. (Specify)				City or Town	n, State)	
		edical	29a. Certifier (Check only one) 1 Certifying Physician: To the ba	best of my know	riedge, death	occurred at the time	e, date and place, a	and due to the ca	ause(s) and manne	er as stated.
	the hin 24 the f the f	Medi	, and marin	er stated.	and or mive					
	T viti	-	29b. Signature and title of certifier	. 4		29c. License			9d. Date signed (N	
	/		I from 18lede 1				6/199		June, 2	9, 2006
	p		30. Name and address of person who completed cause	of death (Item 2	23a) (Type, P	rint)	7	11.5	7,0	
	Stat	e	31. Date filed (Month, Day, Year) 32. Re	gistrar's Signatu	ire A	2011	104520	, 001)	1209	
	Registra		31. Date filed (Month, Day, Year) 32. Date filed (Month, Day, Year)	is to	MODA					

			1 - For State Registrar	State	of Mary	land / Dep <i>Ce</i>	artmen rtificate			nd Me		jiene,	20	06	207	05
	Dhusia		1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	th Day		Vaar	3. Time of D	Death
	Physic /Medi		Agnes V. Con	tee							June	20	20	Year 006	2345	М
	Examii	ner	4a. Facility Name (If not institution	. •	,				Location of D	Death		4c. C	ounty o	of Death		
			Genesis Elder 5. Social Security Number	Care @				apo	lis If Under 24	l.l.o.				Aru		
	Funeral Director		220-56-0758	1 M 2√2 F	7. Age (In	yrs. last birthday, 83 Yrs.	Months	Days		Min.	8. Date of Birth (Month, Day	Year)	2		lace (State or try)	Foreign
			Usual Residence of Decedent						<u> </u>		Apr 8	192	3	Mar	yland	
	rylan		10a. State 10b. County			City, Town or L	ocation							10	Od. Inside City	Limits
	Ba-f s	cto	Maryland Anne	Arundel		Annapo1	is								Yes 2	2 □ No
	with th	Pire	10e. Street and Number				10f. Zip				1	0g. Citize	n of W	hat Count	try?	
	9ath v	erai	o Bens Dr. A	Dt B	adast Com	-110		1403				USZ				
10	fter d	II.	Maryland Anne 10e. Street and Number 6 Bens Dr. A 11. Marital Status 1 XNever Married 2□ Marr	12. Was Dec Armed Fi ied 1 ☐ Yes	orces?	in U.S. 13.	was Deced If Yes, spec	ent of Hi	spanic Origin n, Mexican, P	? (Spec uerto R	cify Yes or No- lican, etc.)	14		- America , White, e		
936	urs a	ā	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi Year or E			1 ☐ Yes	XNo	Specify:			S	pecify:	B1a	ck	
5-0	72 hours after death with the Maryland "natural", or itams 23a or 28a-f show clical Examinet must be notified at	Completed	15. Deceden	t's Education st grade completed)		16a. Dece	dent's Usua	Occupa	ition	Communication .		16b. Kind	of Bus	iness/Ind	ustry	
7	C 2	npie	Elementary/Secondary (0-12)	College (life.	DO NOT us	e retired)	uring most of	WORKING	9					
2	Hygien Hygien Stherti		8th 17. Father's Name (First, Middle,	(ant)		H	omema					Nor				
auc	should be filed and Mental Hygin marked other matic event, II	Be C	Arthur Creek	LdS()							(First, Middle, I	Maiden Si	ımame)		
Maryland 21215-0036	s 1 and 2 should be filed withli f Health and Mental Hygiene. Item 27 is marked other than othar traumatic event, II.e M	2	19a. Informant's Name/Relations	hip (Type, Print)		19b Maili	ng Address	(Street a	Elsie		ray Route Number	City or T	Fourm 6	to to Zin (On dal	
	nd 2 salth ar 27 is r trau		Agnes Booth(I)	1141	1 Bro	owns	Rd.	Upp	er Ma	r1bo	ro	Md	· 207	74
Je,	of Health of Health fitem 27		20a. Method of Disposition		20	b. Place of Dispo cemetery, crei	sition (Nam	e of	1	Da	-			City or Tov		
Ē			1 Burial 2 Cremation 4 Donation 5 Other (S	3 □Removal from pecify)	State Ur	nion U.				-26-	-06 M	cKen	ıdr	ee,	Md.	
Baltimore,	permit. Pag Department Important: any injury c		21. Signature of Funeral Service	Licensee	M.	0 183 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	m ^{Name} Re	Addres	of Eacilist	ns	Mortu	ary,	P	. A .		
			23a. Part1. Enter the disease, or	complications that of	aused the		ZI We er the mode	est of dvina	St. A	nna diac or	polis	, Mo	- 7		1 Approximate	
	Pnysician		Immediate Cause (Final	only one cause on a	each line.	1.01					. cop.iaio.y aire	,		1	Interval Betwe Onset and De	
	/Medical		disease or condition resulting in death)	aDue to	or as a con	sequence of):	La	evet	zni							
	Examiner		Sequentially list conditions	b Ts	chem	in Con	dior	ueno	en noth							
7	pe jis	iner	Sequentially list conditions, any leading to innectal cause. Enter Underlying Cause (Disease or injury	Dua to	(or as a our	sequence of):		1	0						········	
J	and and I-trans	Examin	that initiated events resulting in death) Last	c	(01.00.0.00	sequence of);										
8760,	cate be executed chysician and the burial-transit	<u>a</u>			(0) 43 4 001	soquence (i),										
	ficate physis the	edic		d												
Вох	death certifics e attending ph id for use as t	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pre							230	Date	of delivery	,	
	0 0 0	Physician/M	in the past 12 months? 1 Yes 2 No	4□Pregn	ointh 2 🗍 l ant at time		Ectopic pre Other (spe					200	Month		ay Yea	ir
P.0.	at the d by the stached	hys	9 Unknown	9□ Unkn												
S,	requires that the een signed by th hould be detache	by F	Part II. Other significent condition	ns contributing to de	eath but not	resulting in the ur	nderlying ca	use giver	n in Part I.		23e. Did tob	acco use	contrib	ute to the	cause of deal	th?
ord	w require been sig	ted	Dementia							_	1 Te	s 2 🗆 N	lo 3	☐ Probab	oly 4 Wink	nown
Vital Record	S S	Completed								_	24a. Was an		4b. We	ere autops	sy findings ava	allable se of
E E	cate ha										perform 1 Yes 2	ed?	dea	ath?	□ No	
ŽĮ.	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:						Death (Check only one)				
o	Phys rthis ral dii	1: To	1 Yes 2 No 27. Manner of Death	28a. Date		2 ER/Outpatien 28b. Time of			4 A Tiursin	_	5 Resider					
OU	nding Physiclan: th. After this certifics funeral director, p	tion	1 Natural 5 Pending	(Mont	h, Day Year	Injury	M	c. Injury a Work?	s 2 □ No	200	d. Describe ho	w mjury o	curred			
Division	Atter r dea actor by the	ifica	3 Suicide 6 Could n	ot be 28e. Place	of Injury - A	it home, farm, stre	eet, factory,			28f	Location (Stre	et and N	umber	or Rural F	Route Number	
	s afte	Certification:	4 Homiciae	ouildi	ng, etc. (Sp	ecify)					City or Town,	State)				
	To the Hospital or Attending within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	edical	29a. Certifier (Check only one)	g Physician: To the examiner: On the ba and mann	asis of exam	knowledge, death ination and/or inv	occurred at estigation, i	t the time n my opir	, date and pla nion, death or	ace, and	d due to the car at the time, da	use(s) and le and pla	mann ce, and	er as stated due to the	ed. ne cause(s)	
	To th Within To the	Me	29b. Signature and title of certifier					License i			29	d. Date si	gned (i	Month, Da	ıy, Year)	
)			1//	1			D	610	328				,	/20		
	1		30. Nam and ddress of person v	vho completed caus	e of death (tem 23a) (Type, I	Print) 20	080	onat	60	rise	-/	-//	/	6	
_	7		REINALDO LE			MD,			er, u							
	Sta		51. Date filed (Month, Day, Year)	2000	egistrar's Si	gnature										
	Registra	ar	201 0 3	LUUD A	A160 -	A Ro	30/80									

			1 - For State Registrar	State of Maryla	and / Dep		lealth and	Mental Hy	giene 0 (5 20706
	Physic /Medi		1. Decedent's Name (First, Middle, Lasi	E. C	HAP	MAN	SR	2. Date of Dea Month	ath Day Yea	3. Time of Death
	Funeral Director	ner	4a. Facility Name (If not institution, give Anne Arundel Me 5. Social Security Number 6. Se 218-12-9428	edical Cent	er s. last birthday) 86 Yrs.	Annapo	r Location of Dea 1 is If Under 24 Hr. Hours Min	S. 8. Date of Birt. (Month, Day	v. Year)	cundel Birthplace (State or Foreign Country)
	D	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar		City, Town or Lo	is		Apr 19) 1920 Ma	aryland 10d. Inside City Limits NNYes 2□No
	sath with t s 23a or 2 nual be p	Funeral Director	10e. Street and Number 701 Glenwood St			10f. Zip Code 214			10g. Citizen of What USA	Country?
9036	be filed within 72 hours after death with the Marylar ital Hygiene. do other then "natural", or items 23s or 28s-f show event, its Mudical Exeminar must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba ↑ ☐ Yes 2 No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ai Black, W Specify: T	
21215-0036	within 72 h ene. then "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le campleted) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d)		16b. Kind of Busine	•
Maryland 2	should be filed vind Mental Hygie marked other tumatic event, the	To Be Co	10th 17. Father's Name (First, Middle, Last) Frank Chapman	0	Co	ntracto.	18. Mother's Na	me (First, Middle, or Isacc	Maiden Sumame)	ards Owens
	1 and 2 Health a em 27 ls ther tre		19a. Informant's Name/Relationship (7) Gregory T. Chap 20a. Method of Disposition	man(Son)	701	G1enwoo	d St. A	pt 422	Annapoli	
Baltimore,	permit. Pages Department of I Important: If it eny injury or o		1 X Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	Mei	morial	sition (Name of Party or other plac Gardens Name and Addres	s 6-3	0-06	Davidson ary, P.A	ville, Md.
3760, <	Physician physician and physician and physician and the prital-transit the prital-transit	dical Examiner	23a. Part1. Enter the disease, or compleshock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	ath. Do not ent. BLE paper of): squence of):	ZI West	St. An	napol1S	, <u>Md . 21</u> est,	A01 Approximate Interval Between Onset and Death
P.O. Box 6	death certif e ettending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
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Baltimore,	permit. Pages 1 an Department of Heal Importent: if Item 2 any injury or other once.		21. Sign yur of Funeral Service Lice	nsee //	===							N FU	NERAL H	HOME, P.A.
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	り		30, Name and address of person who	completed cause of	death (Item :	23a) (Typa, F	rine Si	r. 19	balts	. M	14 21>	عرن		
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Amend item#1,perMD,0857,7/5/06 TT

For Amend item#1,perMD, 0859, 9/8/06 TT

Cortificate of Death 1 - For Ar State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elizabeth Ann Branum Herrmann Physician Day Elizabeth Ann Branum Castle Elizabeth Castle 5:30 07/02/06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 23461 Gilpin Point Road Preston Caroline If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 21 ☐ F Director 219-74-4705 50 04/29/1956 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ir then "naturel", or items 23a or 28a-f show the Madical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No by Funeral Director Caroline Preston 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 23461 Gilpin Point Road 21655 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡ No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Office Manager permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygies Important: if item 27 is marked other it any hijury or other traumatic event, the once. Real Estate 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard Branham Evelyn Snow 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Branham / Mother B34 Nature Walk Lane, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/05/06 Elkridge, MD Meadowridge Memorial Park 21. Signature of Francisco Licensee Cary L. Kaufman Funeral Home at Meadowridge Memorial Park, IN 7250 Washington Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Equentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physicien by Physician/Medical the the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ţō Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 2 No 1 Yes 2 No 1∐ Yes Director: After this certific in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Assidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 € No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital or To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D31322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h WAIDEN CHOICE (N GARLO VRADEGP 31. Date filed (Month, Day, Yéar) 32 egistrar's Signature State 0 3 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 2225 PM Genevieve Rose Cieri 29 5006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. ACINES BAUTIMERE HOSPITAL. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | May 24, 1921 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 220-03-6943 85 Yrs. Director Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits worde ! r than "natural", or itema 23a or 28a-f eho tre Medical Exeminer must be notified at 1 ☐ Yes 21 No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1552 Barrett Road 21207 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐kNo Specify: Specify: White ģ 32∰Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than 12 Homemaker Own Home 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be and Mental Anthony Alasha Amelia Cammarotta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other train Daughter 2530 Kensington Gardens #402; Ellicott City, MD 21043 JoAnn Mooney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any njury or once. 4 ☐ Donation 5 ☐ Other (Specify) edral Cemetery 7-3-2006 Baltimore, Marylan 22. Name and Address of FacilitySterling-Ashton-Schwab-Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 New Cathedral Cemetery Baltimore Maryland 21. Signature of Funeral Service Licentee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYOCARDIA INPARCTION-**Physician** ACUTE 1 days /Medical Due to (or as a consequence of): **Examiner** 3We IL DELIR HEAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending physic IF FEMALE 23c. If yes, outcome of pregnancy
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1 □ Yes 2 □ No 24a. Was an autopsy performed? s after deau... ral Director: After this ceru... Division of Vital 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 DING 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after des To the Funeral Directo completely filled in by th 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -18613. Mann. M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE., BALTIMORE, MD-21229 900 MUHAMMAD SAM, MD-CATON 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 0 3 2006

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5	Phys r this ral dir	-: To	1 ☐ Yes 2 Ø No 27. Manger of Death	1 Vinpatient		. Time of	3LI DUA	4 Nursing I	Home 5 ☐ Resi			cify)	
	ding th: Afte	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Y	'ear)	Injury	28c. Injur Wor M 1	k? Yes 2 □No			,		
<u> </u>	Attar ar dea actor by the	ifica	3 Suicide 6 Could not be determined		- At home,	farm, stree	et, factory, office		28f. Location (City or To	Street an	d Number or Ru	ıral Route Number,	
5	ital or rs efte al Dir led in	Cert		building, old. [ороспу,				Ony or 10	m, orare			
	To the Hospital or Attending Physicien: The law within 24 hours elter death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier 1 Cartifying PI (Check only one) 2 Madical Example 1	nysician: To the best of n miner: On the basis of ex and manner states	camination a	ge, death o and/or inve	occurred at the tir estigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time,	date and	place, and due	to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier Date: Well	Jelove	M	D	AT 2	e number 438946	-F14	J4	te signed (Monti	1, Day, Year) 2006,	
	Ŋ		30. Name and address of person who	JELOVAC	, MI	> 6	(NION	MEMOI	RIAL	Ho	SPITA	L, MD	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	anti)						/	
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06-04518 Robert Etkins

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obert Etkins		State of Maryland / Department of Health and 1- For State Certificate of Death Registrar		Reg. No. 200	6 2071
Physici Nedical Exam	an/	1. Decedent's Name (First, Middle, Last) ROBERT ETKINS	2. Date of Dea Month June 27,	ath Day Year	3. Time of Death 1713 hrs
and the second		4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital 4b. City, Town, or L Baltimore		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year O94-26-9192 1 M 2 F 70 Yrs. Months Days Usual Residence of Decedent		irth(MM/DD/YYYY) 9. Birtl 9-36 Foreign Cou	
diow any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 Yes 2 No
Maryland r 28a-f show any ed at once.	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Coun	
with the M ms 23a or 2 be notified	uneral Di		panic Origin? (Specify Yes or No		an Indian, Black,
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygewine Mental Hygewine 72 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	by Fun	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, 3 Widowed 4 Divorced or Pales: Armed Forces? If Yes, specify Cuban, 1 Yes 2 No 1 Yes 2 No	Mexican, Puerto Rican, etc.) specify:	White, etc. Specify: Lih	ITE
72 hours a		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16b. Kind of Business/In	ndustry
21215-0036 uld be filed within 72 Mental Hygiene. marked other than '	Completed		ENTIST 8.Mother's Name (First, Middle,		OVT.
21215 uld be file Mental Hy marked o	To Be (MEYER ETKIN	ANNA REIN and Number or Rural Route Nur	ER	Zin Codo)
and alti	٦	DAVID ETKINS. SON 3703 CREEN SAKW 20a. Method of Disposition (Name of centre) 20b. Place of Disposition (Name of centre)	a RD. HAVREDEGR		78
Baltimore, permit. Pages I al Department of He Important: If ite injury or other tr		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Doppetion 5 Other Specify:			own, State
Balti permit. Departir Imports		21. Signature of the earl Service Licensee 22. Name and its ress of Daugherty Far	of Facility mily Funeral Home And Cre	mation Center, P.A.	()-
Physician /Medical		23s Part T. Enter the disease, go complications that caused the death. Do not enter the mode of dying, s failure. List only one cause on each line	fountain Road - Pasadena such as cardiac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Exsanguination complicating esophagectomy Due to (or as a consequence of):			Death
to entry months	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause C.			
ecuted and transit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
760, cate be execute physician and he burial - trar	Medical	UNPENDED AMENDED			
Box 6876 e death certificat the attending phed for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Pregnant at time of death 5 Other (Specify)	Ectopic pregnancy	23d. Date of delivery Month Da	ay Year
∴ = ≥=	Physician/	1 Yes 2 No 9 Unknown Other (Specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	ven in Part I 23e Did ti	obacco use contribute to the	on equipment death?
S, P.O. uires that the n signed by		Esophageal carcinoma		s 2 No 3 Proba	
Scords he law requi te has been ge 2 should	Completed by			prior to contract of the contr	ppsy findings available mpletion of cause of
Division of Vital Records, ral or Attending Physician: The law requir as after death. al Director: After this certificate has been seled in by the funeral director, page 2 should it.	Be	examiner?	of Death (Check only one)		2 No
of Vi ling Physi After this funeral di	on: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury	at Work? 28d. Describe I	how injury occurred c misadventure	
Visior or Attend ther death birector:	Certification:	Natural 5 Pending Investigation Suicide 6 Could not be Suicide 1713 nrs 1 Ye 28e. Place of Injury - At home, farm, street, factory, office buil	ilding, etc. 28f. Location (\$	Street and Number or Rura	I Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:		4 Homicide determined (Specify) Hospital		ins Hospital, Baltime	
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, of and manner stated. 29c. License	death occurred at the time, date	and place, and due to the	cause(s)
		Zalillos A. O.C.M		29d. Date signed (Month	h, Day,Year)
b		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltin	nore, MD 21201		
S Regis	ate trar	31 Date filed (Month, Day, Year) 32. Registrar's Signature			
DHMH 17 Rev 1/2	001	ORIGINAL			

Decoration Annual Conference and Annual Conference and Annual Annual Conference and Annu				1 - For Amend #10d	State of M &17 Per I'll	arylar G857	7/03/	artmen 06 JF rtificat	of H	lealth a Death	and M	lental Hy	giene 2	006	20712
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Second Second Number Asia		Examir	er				OTD	4b. City,	Town, or				4c. Cou	•	
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Document Document												(Month, Da	, Year) 11926	9. Birthp Cour	itry)
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Physician Medical Examiner Physician Medical Examiner Medical Exa				23a. Part1 Enter the disease, or co	mplications that caused	the deat	h. Do not ent	8900 er the mode	REIS of dying	TERST , such as o	OWN_ cardiac o	ROAD -	PIKES\	/ILLE,	Approximate
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that Initiated events limit the past 12 mgents? Due to (or as a consequence of):		Physician		Immediate Cause (Final	ly one cause on each li	ne.	_					. ,			Onset and Death
Sequentially list conditions, from the past 12 months? Sequentially list conditions and the past 12 months? 23d. Date of delivery 23d. Date of	1	/Medical		resulting in death)	Due to (or as	a consequ		VICE							monoples
State State		Examiner		Sequentially list conditions	b										
Section Sect		B /2/ E	iner	cause. Enter Underlying	Due to (or as	a consequ	uence of):								
Section Sect		and I-tran	хаш	that initiated events	C. Due to (or as	a consequ	uence of):								
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29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of near (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature	a			GE Was some referred to medical	T							1 Yes	2 🗹 No	1 Yes	2□ No
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29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of near (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature	Š	or Att	Ĕ		286. Place of Inf	ury - At ho c. (Specify	me, farm, stre	et, factory,	office		2	8f. Location (Si City or Town	treet and Nu	mber or Rural	Route Number,
30. Name and address of person who completed cause of beam (Item 23a) (Type, Print) W. A. R. Ley G. BMC 670 i N. Charles St. Bolto. Md 2 i 20 x State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		pital urs a srei D		200 Contilion 1 1 1 1 1 1 1 1 1 1											
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State 31. Date tiled (Month, Day, Year) 32. Registrar's Signature		U		W. H. Riley			1 N.	Cha	iles	17.	60	elto n	nd 2	1507	
					P. C.		ure	Les .							

06-04407 Nathaniel E. Fields

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State of Maryland / Department of Health and Mental Hygiene

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Farres	100	\sim	10	(cont	U	- 1	1

		1- For State Registrar		rtificate of Death	- Wientar Ti	_ Reg.	No. 200	16 2071					
Physici ledical Exam		1. Decedent's Name (First, Middle,	F Fiolds			2. Date of Death Month Di June 23, 200	ay Year	3. Time of Death 2002 hrs					
1		4a. Facility Name (if not institution,	give street and number)	4b. City, Town, or	Location of Death		4c. County of Death						
Funeral		3707 Nortonia Road Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace											
Director		100-01/2	1×4 2 F 53	Yrs. Months Days		`	Foreig						
any	Director	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits					
* ;		Md. N	1/4 13			1 Yes 2 No							
death with the Maryland or items 23a or 28a-f sho must be notified at once		10e. Street and Number	. 21	10f. Zip Code	1	10g.	Citizen of What Cour	ntry?					
with the	eral D	3 /07 NOC 72	12. Was Decedent Ever in U	2/2/ I.S. 13. Was Decedent of His	panic Origin? (Sp	ecify Yes or No-	USA 114 Race - Ameri	can Indian, Black,					
or item	Fune	1 Never Married 2 Married	1 Yes 2 No	If Yes, specify Cuban,	, Mexican, Puerto	Rican, etc.)	White, etc.	out mount, black,					
hours after "natural", Examiner	by	3 Widowed 4 Divor	ced If Yes, Give Year or Dates: v only highest grade completed)	1 Yes 2 No		rork done 16	Specify: Blooming	ack					
136 hin 72 hou e. than "nat	letec	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working life.	DO NOT use retir	red)	b. rand of basiness/ii	\(\text{O}\)					
-003 I within giene. Ither tha	Completed	17. Father's Name (First, Middle, L	ast)	Recreation	Leade	(First, Middle, Maid	DEPTOF	Parks					
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Nathaniel T	7. Fields		Eller	/)	Phrey						
Baltimore, MD 21215-0036 Department of Health and Montal Hygiens and present with the Maryland Oppartment of Health and Montal Hygiens in Montal Hygiens in the Maryland Important: If tiens 13% or 28s-f 5the Important: If tiens 13% or 28s-f 5the injury or other traumatic event, the Medical Examiner must be notified at once	7	19a. Informant's Name/Relationship	X.10 1	19b. Mailing Address (Street		tural Route Number	r, City or Town, IIII te,	, Zip Code)					
ore, MD es 1 and 2 sho of Health and If item 27 is		20a. Method of Disposition		Place of Disposition (Name of cerr crematory or other place)		Date 20	nore Md	Town, State					
Baltimore, Permit. Pages 1 and Department of Healt Important: If item injury or other tra		1 Burial 2 Cremation 4 Donation 5 Other Spec		arrison Fores	st 6-	30-2001	Dwings	Wills Md.					
Baltime permit. Pag Department Important: injury or ot		21. Signature of Funeral Service Li	censee	22. Name and Address	RUSS F	Funeral	Home P. F	4.					
Physician		23a. Part I. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Inter											
/Medical Examiner		Immediate Cause (Final disease	a. Atherosclerotic Cardiov		Between Onset and Death								
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.												
	niner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence o	Due to (or as a consequence of):									
35. VE	Examiner	Cipisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
ficate be executed g physician and the burial - transit	Medical	UNPENDED	AMENDED										
3760, ificate be ex g physician s the burial		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg		Estania arasas		23d. Date of delivery	ay Year					
Box 68° death certificate attending ed for use as it	Physician	past 12 months? 4 Pregnant at time of death 5 Other (Specify)											
O. Bo tt the de by the a		Part II. Other significant condition	9 OHKHOWH	23e. Did tobacco use contribute to the cause of death?									
s, P.O nires that t	d by			1 Yes 2 No 3 Probably 4 Unknown									
cords aw requas beer 2 shoul	So No 9 Unknown Part II. Other significant conditions Contributing to death but not resulting in the underlying cause given in Part I. 1												
tal Rec													
of Vital ng Physician: ther this certi	To Be	examiner? 1 V Yes 2 No	Hospital: 1 Inpatient 2		Other:		idence 6 🗸 Other:	Scene					
n of ding Pt After funeral	P.:	27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury 28c. Injury		28d. Describe how	injury occurred						
Division tal or Attendi rs after death. al Director: //	ficati	2 Accident Investig	gation 28e Place of Injury - At he	ome, farm, street, factory, office bu	es 2 No	28f. Location (Stree	et and Number or Rur	al Route Number City					
Divis Hospital or A 24 hours after Funeral Dire	Certification:	Homicide Could not be determined (Specify) or Town, State)											
# 등 보고 하는 이 에어 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to													
To wit To Con	Me	29b. Signature and title of certifier	and manner stated.										
		Large	June 30, 2006										
3		 Name and address of person with Carol Allan, MD Assis 	·	111 Penn Street, Baltimo	re, MD 21201								
St Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	& Soule									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 5 per fh 2857 7-6-06 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 **Physician** Year Jacquelyn Blaire Gibson June 30, 11:35A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4101 Piney Grove Rd. Reisterstown Baltimore Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) \$247-24-13420 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2X5X Director Yrs. 79 March 19,1927 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MDBaltimore Reisterstown 1 Yes XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 4101 Piney Grove Rd. 238 21136 U.S.A. Funeral "natural", or Itams 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married Married □Yes XXNo Yes, Give Baltimore, Maryland 21215-0036 1 Tes XX No ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Sagamore Thoroughbre Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If Item 27 is marked other than any injury or other traumatic event, Ital once. 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) David Taylor Naomi Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles H. Gibson / Husband 4101 Piney Grove Rd. Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial *Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 7/5/06 Baltimore, MD 21. Signature Fineral ervice Licensee 22. Name and Address of Facility Eckhardt Funeral ChapelP.A. 11605 Reisterstown Rd. Owings Mills,MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) nset and Death **Physician** metastatic /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of). Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien a for use as the burial-Records, P.O. Box 68760 Be Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Division of Vital 1 ☐ Yes To the Hospital or Attending Physicien: within 24 hours atter death.

To the Funerel Director: Atter this certifica completely tilled in by the tuneral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12712 3 dress of person who completed cause of death (Item 23a) (Type, Print) MA- 55 750 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 0 3 2006 Registrar

				1 - For State Registrar	State of M		nd / Depa		Health an	d Mental Hy		006	20715		
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2	e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if Item 271s marked other then "naturel" or Itema 23s or 28s-f ehow any Injury or other traumatic event, the Medical Examinat must be notified at an 20se.		20a. Method of Disposition		20b. F		sition (Name of natory or other p		Date		n - City or To			
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4	541		30. Name and address of person who	completed cause of	death (Item 2	23a) (Type, F	rint)	-	Rit	A				-	
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State of Maryland / Department of Health and Mental Hygiene 1 6 For Stete Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1 d 2006 **Physician** June Vashti A. Holt 1548 M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Cheverly Prince George's Hospital Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2√2F 212-38-0557 77 Yrs. June 1929 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "natural", or Items 23a or 28e-f show any njury or other treumatic event, the Mudical Examinat must be notified at once. 10a State 10b. County 1 ☐ Yes 2 1 No Maryland Anne Arundel Harwood Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4691 Sands Rd. 200776 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: Black Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 MDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Anne Arundel Co. College (1-4or 5+) Elementary/Secondary (0-12) 12th Guidance Couselor Board of Education 6yrs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James H. Holt Mary Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leroy A. Battle Jr. (Nephew) 11102 Old York Rd. Mitchellville, Md.20721 20b. Place of Disposition (Name of cemetery, crematory or other place)
Adams U.M. Church 20c. Location - City or Town, State Date 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 6-22-06 Lothian, Md. ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Wm. Reese & Sons Mortuary, P.A. Jarry B. Keese MOO 98 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MINSE COSONUI) Physician /Medical Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last equence of) Due to for as a son Examiner death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) detached the 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes 2 No 1 ☐ Yes To the Hospital or Attending Physicien: within 24 hours after death.
To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saulle 1000 Nade 32. Pagistrar's Signatu 31. Date filed (Month, Day, Year) State JUL 0 3 2006 Registrar

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	leath	erai	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of	, ,	igin? (Specify Yes or n, Puerto Rican, etc.)	No-	14. Race - Amer	ican Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 ie marked other than "natural", or items 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates:	i	If Yes, specify Cut 1 ☐ Yes 2 ☐ No				Black, White	nite
20	72 ho	eted	15. Decedent's E (Specify only highest gi	ducation	16a. Dece	dent's Usual Dccu	pation	st of working	16b. K	and of Business/I	ndustry
21	ithin 19.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	4			Home	
	Hygier Hygier Ither th		17 February Name (First Middle) as	NIA		Homema	7	er's Name (First, Mid	do Maidas		
and	I be fi	Be	17. Father's Name (First, Middle, Las	· .			0	0		(Sumanne)	
Maryland	hould d Me mark matic	2	19a. Informant's Name/Relationship		19b. Maili	na Address (Stree	-	t (+ (<o()< td=""><td></td><td>or Town, State, Zi</td><td>n Code)</td></o()<>		or Town, State, Zi	n Code)
<u>≅</u>	nd 2 sho lith and 27 ie ma		Robin Buckh			6 ASPER			11	MO 2	1234
ē,	s 1 ar f Hee item othe		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of matory or other pla		Date		ocation - City or T	own, State
Ę	Pages ient of nt: If if		1 Surial 2 Cremation 3 (4 Donation 5 Other (Spec		LAIR	a em	tern	7/6/06	Bes	AIR, M	S
Baltimore	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lice	Stella		Name and Addr AUL STC	ess of Facili	y enal Ho	me, F	NP 218	774
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the deat	th. Do not en	er the mode of dy	ing, such as				Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	Cand	pe o	enhy	m	nie			Onset and Death
1	/Medical		resulting in death)	Due to (or as a conseq	uence of):	1.0		· · · · P			1
	Examiner		Sequentially list conditions,	b. LSCRE	mz	calors	My	gen			YEMS
	₹ % ₹	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):			'			arm o
	and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):						701105
68760,	cate be executed bhysicien and the burial-transit	ical		1413 P							YEAR
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	that the death led by the etter detached for i	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	ieath 5	J Other (specify) _			-		
P.0	that the bod by detail		Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause gi	ven in Part I	. 23e. D	d tobacco i	use contribute to	the cause of death?
sp.	uires that n signed t	Q P	LOPD					11	Yes 2	□No 3□Pro	bably 4 □Unknown
Records,	s been si should	Completed by	DIMBETE	S MELLIT	rus			24a. W		24b. Were aut	opsy findings available ompletion of cause of
Re	The lav	E o					-	at pe 1□ Ye:	topsy rformed? 2 2 00	death?	2 No
Vital		BeC	25. Was case referred to medical				26. Place	of Death (Check on		12.100	
of V	nysiclan: nis certific I director,	70 E	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3□ DOA Ot	her: 4 🗆 Nu	ursing Home 5 R	sidence	6 □Other (Speci	fy)
0 0	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo		28d. Describ	e how inju	ry occurred	
Division	or Attendin efter death. Director: Aft in by the fur	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	20]Yes 2 🗌		(0)		
Ξ	ofter de Direct	T.	4 Homicide determined		ome, tarm, sti fy)	eet, factory, office			(Street an Town, State	nd Number or Rur))	al Route Number,
	pital ours e eral (Ce	29a. Certifier 1 Certifying P	hysician: To the best of my kno	wiedne deat	h occurred at the ti	imo data as	ad alace, and due to t	30.00.00(6)	l and manner on	Nata-d
	Hospita 24 hours Funeral etely filled	edicai	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my	opinion, dea	th occurred at the tim	e, date and	d place, and due t	to the cause(s)
	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and title of certifier				se number		29d. Da	te signed (Month,	Day, Year)
	> PT 0		1-150/Pa	Lo Mis			127		61	30/2	006
	7		30. Name and address of person who		п 23а) (Туре,	Print) 75	505	N M	2 0	MUE	
			FERNANDO,	4 DELGAD	0	To	OWSO	N M	0	2120	4
	Sta		31. Date filed (Month, Day, Year)	32. Pagistrar's Signa	ature						
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		1 - State Registrar Amend #17&18 I	ate of Maryland er FH G857 7	Departme /03/06 J	nt of He He Ite of D	alth and M <i>eath</i>	fental Hyg	giene	06 20719	
Physic /Med		Decedent's Name (First, Middle, Last) LOUIS		HUN0	VICE		2. Date of Dea Month	Day 29	Year 06 7 15A	
Exami	ner	4a. Facility Name (If not institution, give street LEVINDALE HEBREW H()ME	В	ALTIMO			4c. County	of Death N/A	
Funeral Director		5. Social Security Number 216-16-2389 Usual Residence of Decedent	7. Age (In yrs. last	Yrs. Month		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 07/11/1	917	Birthplace (State or Foreig Country) MD	
h the Maryland ir 28a-f ahow	tor	10a. State 10b. County BALTIMORE		own or Location					10d. Inside City Limits 1 ☐ Yes 2 No	
	Director	10e. Street and Number		10f. 2	ip Code		1	10g. Citizen of V	•	
€ 23	Funeral	6659 C SANZO ROAD 11. Marital Status 12. W	as Decedent Ever in U.S.	13 Was Dec	21209	anic Origin? (Sp	noifu Voc or No		J.S.A. e - American Indian,	
after or ita	by	1 Never Married 2 Married 1	rmed Forces? □Yes 2 X No Yes, Give ear or Dates:	ii res, sp	ecity Cuban,	Mexican, Puerto Specify:	Rican, etc.)		ck, White, etc.	
	leted	15. Decedent's Education (Specify only highest grade con	n 16	6a. Decedent's Us (Give kind of v	rork done duri	on ing most of worki	ing	16b. Kind of Bu	usiness/Industry	
be filed within tal Hygiene. Id othar than "avant, It e Wes	Completed	Elementary/Secondary (0-12) C	oilege (1-4or 5+)	WNER & F				MARYLAN	D EQUIPMENT	
d 2 should be filed within ith and Mental Hygiene. 17 Is marked othar than "treumatic avant, Its Mes	To Be C	17. Father's Name (First, Middle, Last) SAMUEL	Hunovice	HANOVIC		3. Mother's Name SARAH	(First, Middle, I		HONOVICE	
s 1 and 2 should f Health and Men itam 27 is marke othar treumatic	_	19a. Informant's Name/Relationship (Type, P		9b. Mailing Addre						
1 and Health tam 27		FREIDA HUNOVICE / V 20a. Method of Disposition		6659 C S of Disposition (N		-	the second secon	-	209 City or Town, State	
0 0		1 Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)		tery, crematory or	other place)	RK 06/30			STOWN, MD	
permit. Pages 1 and Department of Health Important: If itam 27 any injury or other tr 2002.		21. Signature of Funeral Service Licensee	1	22. Name	and Address o	of Facility SC	L LEVIN	SON & B	ROS., INC. LLE, MD 21208	
		23a. Part1. Enter the disease, or complication shock, of hear fail ire. List only one cau	ns that caused the death. Duse on each line.						Approximate Interval Between	
Pnysician /Medical		Immediate Cause Fi II disease ir condition resulting in death) a	Lower Or	meter	stina	1 K/c	eding		Onset and Death	
Examiner	ı		Due to (or as a consequence of):							
B 10 15	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequenc	e of):						
and and	Examin	that initiated events c.	Due to (or as a consequenc	ee of):						
cate be executed physician and	dical E	d								
	Medi	IF FEMALE:								
The law requires that the death certifics ate has been signed by the attending phage 2 should be detached for use as t	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal dea □ Pregnant at time of death □ Unknown	th 3 ☐ Ectopic 5 ☐ Other (s				23d. Date Mon	e of delivery Ith Day Year	
uires that i signed by Id be deta	by	Part II. Other significant conditions contribut	ing to death but not resulting	in the anderlying	cause given in	n Part I.	23e. Did tob	10	bute to the cause of death? 3 Probably 4 Unknown	
aw requir is been si 2 should	plete	Hypotension					24a. Was ar	24h W	/ere autopsy findings available	
	Completed	1370010113101					autopsy perform 1 Yes 2	pr ped? de	rior to completion of cause of eath? Yes 2 No	
Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	sl•		0.1	. Place of Death		9)		
F a F a	T: To	163 2	I. Date of Injury 28b	Outpatient 3 D	OA Other:	Jursing Hom	ne 5 Resider 8d. Describe ho			
ttanding I death. ctor: After y the funer	atlor	1 Hatural 5 Pending investigation	(Month, Day Year)	Injury M	Work?	2 🗆 No	2 - 2 - 2 - 1 - 1 - 1 - 1	w injury cocurre		
al or Attands after death	Certification:	3 Suicide 6 Could not be determined 286	Place of Injury - At home, building, etc. (Specify)	farm, street, factor	y, office	2	8f. Location (Str. City or Town,	eet and Numbe State)	r or Rural Route Number,	
To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical (Violet only	To the best of my knowleder the basis of examination and manner stated.	ge, death occurred	at the time, on, in my opinion	date and place, a on, death occurre	nd due to the ca d at the time, da	use(s) and man te and place, ar	ner as stated. nd due to the cause(s)	
To the To the comp	Ň	29b. Signature and tipe of certifier	1	29	c. License nu	mber	29	d. Date signed	(Month, Day, Year)	
^		Ju 111. 9	7/10	1.	133	1943	5	1120	9/04	
7		30. Name and address of person who complete	d cause of death (Item 23a) (Type, Print)	PIAL	dula	,	6		
Sta		31. Date filed (Month, Day, Year)	32 a gistrar's Signature		CVIV	viul (
Regist	ar	.1111 0 3 2006	Maria K	Books	9					

ORIGINAL

06-04406 Morris Jackson

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental He

MOTHS SUCKSOIT		1-For state Registrar Certificate of Death	al Hygiene 200	6 2072
Physicia Medical Examir		1. Decedent's Name (First, Middle, Last) Tack Son	2. Date of Death Month Day Year June 23, 2006	3. Time of Death 1625 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of 2305 Etting Street Baltimore City		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	(
Director		212-46-8818 12 M 2 F 57 Yrs. Months Days Hours Usual Residence of Decedent		untry) Md
ow any		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show d at once.	Director	Naryland Nitt Daitimore 10e. Street and Number 10f. Zip Code	10g. Citizen of What Cour	
with the Maryland ns 23a or 28a-f sho be notified at once		1425 Madison Ave. 21217 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	USF	}
er death v	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	Puerto Rican, etc.) White, etc.	can Indian, Black,
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	ed by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT u	nd of work done 16b. Kind of Business/I	ack ndustry
5-0036 led within 72 h Hygiene. other than "r	Completed	Elementary(Secondary (0-12) College (1-4 or 5+) Thule Oe indepth of the control	integrator Floor	tria
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be Cor	17. Father's Name (First, Middle, Last) Norris Eli Jackson Rui	Name (First, Middle, Maiden Surname)	110
D 2121 should be fi and Mental is marked atic event,	TO B		per or Rural Route Number, City or Town, State	ans Zip Code) 1543
imore, MD 2121; Pages I and 2 should be fil ment of Health and Mental I laut: If tiem 27 is marked or other traumatic event.;		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, J. Removal from State crematory or other place)	ton St. Mamarone 20c. Location - City or	CK, N. Y. Town, State
Page Page nent o		4 Donation 5 Other Specify: Wood awn (remotery)	7/1/2006 Bronx	N.Y.
Balti permit. Departi Import injury		21. Innature of Funeral Service Licensee 22. Name and Address of Eacily 05ep h. Rus	Sy Funeral Home, P	A. 16
Physician /Medical		23a Tart I. Enter the disease, or combrications that caused the death. Do not enter the mode of dying, such as car ailure. List only one cause on each line. Immediate Cause (Final disease a. Cirrhosis of liver	diac or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. CITTIOSIS OF LIVET Due to (or as a consequence of):		Dean
w.	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
ted 1 Insit	Examiner	(Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		<u> </u>
760, icate be executed physician and the burial - transit	Medical	w AMENDED item#20a,23a,27,perFH,ME,g857,7/27	7/06 TT	
68760, ertificate be	an/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic p	23d. Date of delivery	ay Year
that the death certified by the attending detached for use as	hysician/	1 Yes 2 No 9 Unknown 9 Unknown Other (Specify)		
- 8 90 m	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	I. 23e, Did tobacco use contribute to the contr	
cords, law require has been si	Completed		24a. Was an 24b. Were aut	opsy findings available ampletion of cause of
tal Recc cian: The lav certificate ha		25. Was case referred to medical 26 Place of Death (C	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been si led in by the funeral director, page 2 should be.	ň	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DCA Other 1	heck only one) Nursing Home 5 Residence 6 Other:	Scene
on of ending Phath. or: After the funeral	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 N	28d. Describe how injury occurred	
Divisi al or Att s after de al Directe	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specific) (Specific)	28f. Location (Street and Number or Rura or Town, State)	al Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	e, and due to the cause(s) and manner as starte	d.
To the Howithin 24 h	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated. 29b. Signature and title of certifier 29c. License number	rred at the time, date and place, and due to the 29d. Date signed (Mont	cause(s)
		Werforte Me World O.C.M.E.	June 24, 2006	n, Day, rear)
		Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, I	MD 21201	
Sta Registr		31 Date filed (Month, Day, Year) 32. Begistrar's Signature		
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State of Maryland / Department of Health and Mental Hygiene [] []

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			1 - State Registrar		Ċ	ertificate of	Death	B	eg. No.	-0161
-	10		1. Decedent's Name (First, Middle	Last)				2. Date of Dea	th	3. Time of Death
1	Physic /Medi		Eric Johnson					June 2	27, Day 2006 Year	3:48 AM M
	Exami		4a. Facility Name (If not institution,	give street and number)		4b. City, Town,	or Location of Death		4c. County of Dea	
*			Joseph Richey	Hospice		Baltin	nore		:	
	Funeral Director	3000	5. Social Security Number 213-64-0012	6. Sex 7. Ag 11∏ M 2 ☐ F	e (In yrs. last birthd 47 Yrs	Months Days		8. Date of Birth (Month, Day Jan 10,	Year) 9. Bir	thplace (State or Foreign ountry)
- 33	*		Usual Residence of Decedent		47			Jan 10,	1939 Mar	yland
	yland		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mac	to	MD		Baltimo	re				1 ▼ Yes 2 □ No
	h the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?
	th wit	a D	828 N. Eutav	Street		2	1201		USA	
	dea dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ame	
036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show ta Medical Exemirar must be notified at	Completed by Funeral	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🔀 Divorced	lf Yes, Give Year or Dates:	10	1 ☐ Yes 2X No		o Hican, etc.)	Black, Whit	
2-0	72 h	etec	15. Decedent' (Specify only highest	Education	16a. De	cedent's Usual Occu	pation	unk	16b. Kind of Business	/Industry unk
21215-0036	d within giene. or then	omple	Elementary/Secondary (0·12)	College (1-4or 5	i+)	ive kind of work done e. DO NDT use retire	ad) "I won	Siriy		
b	e file al Hy l othe vent,	Be	17. Father's Name (First, Middle, L	ast)			18. Mother's Nam	ne (First, Middle, M	Maiden Surname)	unk
<u> a</u>	uld b Menta	To	Thomas	Johnson						
Maryland	2 sho and 1 is ma		19a. Informant's Name/Relationsh	p (Type, Print)	19b. Ma	ailing Address (Street	t and Number or Ru	rai Route Number,	, City or Town, State, J	Zip Code)
	and and n 27		Janet Kissinger	/friend	28	320 Ross A	venue Bal	timore,	MD 21219	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examinational Permutitied at Once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other (Sp		20b. Place of Discemetery, of	sposition (Name of rematory or other pla	(ce)	Date	20c. Location - City or	Town, State
Balt	permit. Depertition of the point of the poin		21. Signature of Funeral Service L Ronald S	· Wade Dire	ector	22. Name and Addre State Anat Baltimore.	ess of Facility Comy Board MD 21201	1 655 W.	Baltimore	Street
	Physician /Medical		23a. Part 1. Enter the disease, or or shoot, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	notications that caused the death. Do not enter the mode of dwing, such as cardiac or recoveratory arrest						Approximate Interval Between Quest and Death
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13	TK.	ē	Sequentially list conditions, if any, leading to immediate	ue to (or as	a consequence of):					while
	insit	Examiner	Cause (Disease or injury							
Ć,	exection and in all tra	Exa	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
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.O. Box	death o	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetel death	B Ectopic pregnanc C Other (specify)	у		23d. Date of deli Month	ivery Day Year
0	that led by deta	4	Part II. Other significant condition	s contributing to death bu	it not resulting in the	underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Records,	law requires that the as been signed by th 2 should be detache	ted by						1 □ Ye	\checkmark	
	The ate h page	Completed						24a. Was an autopsy perform	led? death?	topsy findings available completion of cause of
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one		,
Division of \	iing Phys n. After this funeral di	Certification: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident Investiga	Hospital: 1 Inpatier 28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Injur	4 Nursing Ho	me 5 Resider 28d. Describe hor	nce 6 Other (Spec w injury occurred	in Hospice
ls!	r Attendi er death. rector: A i by the fu	fica	3 ☐ Suicide 6 ☐ Could no	t be One Blees of Init	ry - At home, farm,			28f Location (Str.	eet and Number or Ru	iral Boute Number
Š	after after Dire	ert	4 Homicide	building, etc	. (Specify)	ones, radiony, onless		City or Town,	State)	rai mobile Municer,
	To the Hospital of within 24 hours at To the Funeral D completely filled it	edicai C	29a. Certifier 1 Certifying (Check only one) 2 Medical E.	Physician: To the best of teminer: On the basis of and manner stall	examination and/or	ath occurred at the tir	me, date and place, ppinion, death occurr	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 /		29c. Licens	e number_	29	d. Date signed (Month	n, Day, Year)
	- 5 m Ö		MAN	No	MD	DI	257	2_	6 27/2	orle
			30. Name and address of person w	LISS, M	D. 2	Hamill	Ra Smit	1315	3alfuno	R MD 21210
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registra	r's Signature	have			*	

due 6/27/06 3:48AM

ERIC JOHNSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death 2. Date of Death 3. Time of Death $July^{Month} 2, 2006$ Α. Kropff Jr. 8**:**10 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month. Day. Year) | Jan. 25, 1923 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 JM 2□ F 83 Pennsylvania

1. Decedent's Name (First, Middle, Last) **Physician** Clement /Medical 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center for Hospice 5. Social Security Number 189 14 6613 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2018 Middleborough Road 21221 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1943–46 Specify: δ Specify: White 3℃Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Supervisor Auto Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clement A. Kropff Sr. Mary Augustine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Freyer - Daughter 2018 Middleborough Road Essex Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Holly Hill Mem. Gardens 7/8/2006 Baltimore Co., Maryland XX Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) ature Funera Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 t1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause in each line. Immed the Cause (Final diseas or condition resulting in death) Sersis Syndram Due to (or as an insequence of): AIRM Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of):

Pnysician /Medical **Examiner**

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum once.

Funeral

Director

ir than "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at

physicien and stransit

Physician/Medical attending p ed by the a ģ Completed director, this

P.O.

Division of Vital Records,

or Attending

funeral After Certification: by the

1 Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

1 Natural

within 24 hours after death. To the Funeral Director: A

filled in

Medical

State Registrar IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death

5 Other (specify)

3 Ectopic pregnancy

23d. Date of delivery Month Day

1 ☐ Yes 2 ☑ No

23e. Did tobacco use contribute to the cause of death?

Year

Approximate Interval Between Onset and Death

weeks

10d. Inside City Limits

USA

1 Yes 2 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronpry

24a. Was an 1□ Yes 2□ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

3 Probably 4 Unknown

25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) + 5 Pico 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

· mo

25205

30. Name and address of person — o completed cau — of death (Item 23a) (Type, Print) R. 6BMC

6701 N. Charles St. Balto. Md 21204

2006

31. Date filed (Month, Day, Year)

3 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Amend #5 Per FH G858 8/02/Gertificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE 29, 2006 **Physician** Esther L. Kowalewski 1:32 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 924

Yrs. Months Days Hours Min. Apr. 20, 1924 Birthplace (State or Foreign Country)
 VA 5. Social Security Number 6. Sex **Funeral** 1□M 2□F Director 407-21-5168 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at L∏Yes 2 No Director Bel Air Md. Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21014 232A Crocker Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: white 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) waitress food service 12 years permit. Pages 1 end 2 should be filed w Depertment of Health and Mental Hygier Important: if Item 27 is marked other ti any Injury or other traumatic avent, Im odd. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Magdeline Cabin Len Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1647 Aberdeen Road, Towson, Md. 21286 Ronald Kowalewski/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 7/1/06 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signaure of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. Siruke 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** CLOSTRIDIUM DIFFICILE COLITIS /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ng physicien and as the burial-transit WEGENERS GRANULOMATOSIS Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical ed by the attending detached for use as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ icete has been sig r, page 2 should b 3 Probably END STAGE RENAL DISEASE 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has autopsy performe 2 No 1☐ Yes 2 X No 1 Tyes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident Injury 5 Pending after death. 1 Tes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Dire 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature applittle of certifier 29c. License number 29d. Dale signed (Month, Day, Year) D 24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON MARYLAND 21204 TIMOTHY LOW M.D. 62. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 3 2006 Registrar

			For Amend #19a&2	State of Maryland 6 Per Phy&FH g	d / Depa 857 _{Ce} /	rtment of H 03/06 JH tilicate of t	ealth and M Death	lental Hyg	iene2006	20724
	Physicia	ın	Decedent's Name (First, Middle, Las LYNN			KREII		2. Date of Deat JUNE 2	h Day Year	3. Time of Death
Salar I	/Medic Examin		4a. Facility Name (If not institution, give 2321 CAVESDALE R			4b. City, Town, or OWINGS	Location of Death		4c. County of Deat	
	Funeral Director		301-30-3312	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08/17/1	9. Birt 939	hplace (State or Foreign untry) MI
	•how	or	Usual Residence of Decedent 10a. State 10b. County NY		, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28a-f	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	·
	ne 23e	eral	2511 MAIN STREET 11. Marital Status	12. Was Decedent Ever in U.S	S. 13. V	Was Decedent of H	12946 ispanic Origin? (Sp	ecify Yes or No-	U.S.A.	rican Indian,
036	72 hours after death with the Maryland Instural, or Itema 23a or 28a-f ehow deal Examinations for notifies a	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		v	n', Mexican', Puerto Specify:	Rican, etc.)	Black, Whit	e, etc. WHITE
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "netural; or liems 23a or 28a-1 show or other traumatic event, the Modical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	contion de completed) College (1-4or 5+)	(Give	DO NOT use retired	during most of work	ing	16b. Kind of Business	·
nd 2	be filed tal Hygi d other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	Maiden Sumame)	
Maryland	should nd Men marks imatic	7	MARTIN 19 Informanti Name/Relationship (7	-	WEISS 19b. Mailin	ng Address (Street	IRENE and Number or Run	al Route Number	SIE City or Town, State, 2	GEL Zip Code)
	and 2 ealth ar m 27 le		EDWARD KREIL / H	N S R W D					N.Y. 12946	
nore	Pages 1 nent of H ant: If its		20a. Method of Disposition 1X☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	ace of Dispo emetery, cren SINAI	sition (Name of natory or other place CONG.	(e)		20c. Location - City or WINGS MILL	
Baltimore,	permit. Pages Department of Important: If i eny Injury or e		21. Signature of Funeral Service Licen		22	. Name and Addre	ss of Facility SO	L LEVINS	ON & BROS.	, INC.
2	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	olications that caused the death one cause on each line.	Do not enti	er the mode of dyin	g, such as cardiac	or respiratory arro		Approximate Interval Between Onset and Death
<i>F.</i>	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ	uence of):	1 0011	Long	Cane	•	4 Months
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	ience of):	-				
8760,	icate be executed physician and site burial-transit		that initiated events resulting in death) Last	Due to (or as a consequ	ience of):					
9	n certificate anding phys use as the	Medic	IF FEMALE:	d						
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-trangit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetel 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
<u>α</u>	uires that t signed by id be detac	þ	Part II. Other significant conditions c	ontributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	pacco use contribute to	o the cause of death?
of Vital Records,	The taw requir ate has been si page 2 should I	Completed						24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
Vital	Physician: T this certificat ral director, p.	Be	25. Was case referred to medical examiner?	Hospital:		Oth	00	h (Check only on	(6)	Daughter's
on of		lon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Abordent Investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	f 28c, Injur Wor	v at		ence 6 Nather (Spe	(city)Residence
Division	l or Attending after death. Director: After	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, str			28f. Location (Si City or Town	reet and Number or R. n, State)	ural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in I	edical C	29a. Certifier 1 Certifying Ph	ysician: To the best of my kno- niner: On the basis of examinal and manner stated.	tion and/or in	vestigation, in my o	pinion, death occur	red at the time, d	ate and place, and due	e to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	lean ONCOL	06-15	29c. Licens	56919	2	9d. Date signed (Mont	h, Day, Year)
The	10		30. Name and address of person who	Donegan	1 23a) (Type,	Print) 569 N	Charte	s St. "	Bultymore	ih, Day, Year) OE EM) 2120Y
	Sta Regist		31. Date filed (Month, Day, Year) JUL 0 3 200	32 Registr r's Signa	ture	while				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 30. June 2006 Рм Jin Kim 2:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec 28, 194 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** 217-69-7233 61 Director Japan Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County *ehow other traumatic avant, the Medical Examiner must be notified at 1 Yes 2 No Director MD Baltimore Towson 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò 20 Acorn Circle Apt. 201 21286 "natural", or Itams 23a South Korea death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Korean À 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Itam 27 is marked other than "any injury or other traumatic avant, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Building Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kwae Young Kim Sun Nam Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sook Ja Lim wife 20 Acorn Circle Apt. 201; Towson, MD 21286 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ↑5 ☐ Other (Specify) Hilltop Service Corp 7/3/06 Towson, MD 21. Signature of uneral Service Ligensee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER **Physician** 5 ASTRIC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physicien end Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, pega 2 should be detached 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 ☐ Probably 4 Dunknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 D No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Diractor; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in Contrying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29s Conflie (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/30/06 D43725 10 2300 Dulaney Valley RD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahmood

Registrar DHMH 17 Rev 1/2001 aria

31. Date filed (Month Day, Year)

JUL 0 3 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene [For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) . ^{Day} 2006 June 29. 4:18 A^{M} **Physician** Allen Lucas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Middle River 1204 3rd Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | March | 13, 1928 | West Virginia 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral 1**5 M 2□ F 78 220-16-7053 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Expire is must be notified at 1 ☐ Yes 20 No Middle River Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21220 U.S.A. 1204 3rd Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No 1945-1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: If Yes, Give Year or Dates: 1947 White þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 Is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) Bethlehem Steel Steel Worker 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bertha M. Idleman William Henry Lucas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1204 3rd Road, Baltimore, Maryland 21221 Wanda Lucas (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If it eny injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. July 1,2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdziński Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Fundral Selvice Licensee 20a. Part1. Ender the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION Physician /Medical CAPDIENASCULAR DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) Yes 2 No 9☐ Unknown 9 I Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown METABOLIC SYNDROME 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has CHRENIC OBSTRUCTIVE 1 Yes 2 ≥ No 26. Place of Death | Check only one within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ 10 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Matural or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital owithin 24 hours aft To the Funeral Di 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier marley 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUN 31. Date filed (Month, Day, Year) State 0 3 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Year JUNE LEVINE 29 2006 CYNTHIA JOAN 9:22P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4245 MARY RIDGE DRIVE RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 04/28/1956 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🙀 F 50 Yrs MD Director 214-68-2937 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits *how r than "natural", or items 23s or 28s-f shov the Medical Exempler must be notified at Director 1 ☐ Yes 2 No MD BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4245 MARY RIDGE DRIVE 21133 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after conent of Health and Mental Hygiene.
Int: If Item 27 is marked other then "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) PHARMACIST PHARMACY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **BROWN** ANNA POMERANTZ NATHAN 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4245 MARY RIDGE DRIVE-RANDALLSTOWN, MD 21133 BARRY LEVINE / HUSBAND 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/30/2006 BETH TFILOH CONG WOODLAWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. VICE 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA disease or condition resulting in death) ASPIRATION /Medical Due to (or as a consequence of): Examiner ON'S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ý transit To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical use as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 40 23d Date of delivery 3 DEctopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: At 1 Yes 2 No Director: 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 4 \ Homicide 1 ▼Certifying Physician: To the best of my knowledge, death encurred at the time, date and place, and due to the cauca(e) and manner as stated.
2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D005465 June 30, 2006 416 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ; 2360 W. JOPPA RD SUITE ZIO; Lutherville, MD 21093 Holly R Dahlman, MD 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 3 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 29, June 2006 6:00 A M Eleanore M. Lukowski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Joseph Nursing Home Baltimore Catonsville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | Nov. 25, 1917 | Massachusetts 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Yrs 88 Director 020-12-3568 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 A Yes 2 No Director Baltimore Md n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21231 23a 807 S. Ann Street USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Itams 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 MWidowed 4 □ Divorced White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n St. Patrick's College (1-4or 5+) Elementary/Secondary (0-12) Teacher School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Annie Conroy William Francis Heanue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 Is rr any injury or other traum 8310 Winter Wind Ct. Ellicott City, Md. 21043 Thomas M. Lukowski (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cem. 7/3/06 Dundalk, Md. 21. Signature of Funeral Service Licensee KadrorowskoffacTuneral Home P.A. once. Robert 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Two Weeks disease or condition resulting in death) a Bilateral Broncho Pneumonia /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Years Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗷 No P.O. detached the 9☐ Unknown 9 Unknown s been signed by ti should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Senile Dementia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Osteo Arthritis has autopsy performed certificate 2 No 1 Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 SNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after deat To the Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital or 29a, Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) D_30469 June 29, Columbia, Md. 21045-2877 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vellanki 8850 Columbia 100 Parkway #308 Nandakumar В. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUL 0 3 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Time of Death Decedent's Name (First, Middle, Last) Month Year 9:45 PM Physician UNE JAMES HARRY MARTIN 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner ANNE ARUNDEL GENESIS ELDERCARE OF SEVERNA PARK SEVERNA PARK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta Country)
FEB. 15, 1929 MARYLAND 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1X M 2□ F 218-22-1515 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b County 10a State or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MARYLAND BALTIMORE COUNTY **ESSEX** Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21220 4 MERSEY CT. UNITED STATES Iteme 23a Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 (2) Yes 2 □ No 1 Yes, Give Year or Dates: 146-148 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married 10. Specify. WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PURCHASING AGENT HOSPITALITY 6 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any linjury or other traumatic event 2016. 17. Father's Name (First, Middle, Last) Be VIRGINIA BROOK JOHN MARTIN ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SHARON CUCINA / DAUGHTER 8017 HORICAN POINT DR., MILLERSVILLE, MD 21108 JULY 3 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 2 ☐ Cremation 3 ☐ Removal from State CROWNSVILLE MD VET. CEM. 2006 CROWNSVILLE, MARYLAND ation 5 Sther (Specify) ure of uneral S 21. Sign 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A.
421 CRAIN HWY., S.E., GLEN BURNIE, Particular the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21061 Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and store use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö the 9 Unknown 9 Unknown Records, P. 23e. Did lobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Mainthown CEREBROVASCULAR Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 45 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No P 28a. Date of Injury (Month, Day Year) After this funeral of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral Certification: 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury · Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JULY 03, 2006 D57531 mi) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Veterans May, Millersville, nod 21108 NEST Mobil 32. Registrar's Signature 31. Date filed (Month, Day, Yest) State Registrar 0 3 2006

Please Type or Print in Black Indelible Ink

April McCullum State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 29, 2006 Medical Examiner 0147 hrs 4a Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 4c County of Death Johns Hopkins Bayview Baltimore 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State of 5 Social Security Number 7, Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** Months Days Hours Director 13-04 MArch 29 Country) М Yes 2 No 28a-f show Funeral Director 10g Citizen of What Count MORAVIA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black Married Yes Yes 2 No specify Divorced If Yes, Give Year . Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. "rant: If item 27 is marked other than "natural", or other tranmartic event, the Medical Examiner. ģ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done Completed Elementary/Secondary (0-12) Baltimore, MD 21215-0036 ashier 17. Father's Name (First, Middle, Last) McColl om æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Codi 20b. Place of Disposition (Name mportant: Specify. Dona Part I Enter the disease failure. List only one of Physician use on each line Between Onset and /Medical Death a. Asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Thermal Injury to Trachea Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical physician the burial -UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Records, P.O. ģ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed' death? 2 No Yes 2 1 Yes To the Hospital or Attending Physician: 26 Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other After this 1 Yes 28a Date of Injury (Month Day Year 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject burned upper airway Jun 29, 2006 2300 hrs 1 Natural 5 Pending 1 Yes 2 ✔ No To the Funeral Director: 2 🗸 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined (Specify) Multi-Family Apt. 6065 Moravia Park Drive Apartment C4, Baltimor 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. June 30, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Susan Hogan MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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			For State Registrar	State of	Marylan		artment of H				2000	20731
			Decedent's Name (First, Middle, L.)	ast)						ite of Death	J. No.	3. Time of Death
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	_/Medic	100	4a. Facility Name (If not institution, g.	ive street and numb	nor)		4b. City, Town, or	r Location (of Death	~ ·	4c. County of De	
	Examin	er	0	0 0	AGI)		<u> </u>				4c. County of De	aui
			Genesis Honew		Acc /laum	last histhday)	If Under 1 Year	If Under		te of Birth	0.8	irthalana (Stata ar Fareira
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	pug ≱	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
	sho	7										1√2 Yes 2 □ No
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	or 2	Dir.	10e. Street and Number				10f. Zip Code			10	g. Citizen of What (country?
	ath v	Funeral Director	6000 Bellona Av					212			USA	
	ems err	ne	11. Marital Status	12. Was Deced Armed Ford	es?	.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	lispanic Ori an, Mexicar	igin? (Specify Y n, Puerto Rican,	es or No- etc.)	14. Race - An Black, Wh	
õ	illed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or items 23s or 28s-f show ant, the Madical E-sammar must be mailtied at	Ϋ́F	1 Never Married 2 Married	1 □Yes 2 If Yes, Give Year or Dat	X No		1 ☐ Yes 2 ☑ No	Specify:			Specify: b	1ack
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yıand	s 1 and 2 should be filed within 72 hours after death with the Marylan If Health and Mental Hygiene If Health and Mental Hygiene Item 27 is marked other then "naturel", or items 23s or 23sa-I show then traumatic event, the Medical Frantifier manks in clitted at	2	Oscar Hooper Jo	hnson				Sad	ie Flor	ee Gro	ove	
Mar	s ma		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street a	and Numbe	ər or Rural Rout	e Number, (City or Town, State	Zip Code)
Σ	and 2 lealth i m 27 I		Genesis Homewood			6000	Bellona	Aven	ue Balt	imore,	, MD 212	12
ē,	f He f He ltem othe		20a. Method of Disposition				sition (Name of natory or other place	na)	Date	20	Oc. Location - City of	or Town, State
2	age ant o ht: If y or		1 ☐ Burial 2 ☐ Cremation 3 `4 ☒ Donation 5 ☐ Other (Spec		ate	omotory, area	natory of out of place					
Baitimor	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.			**		22	2. Name and Addres	ss of Facili	tv			· · · · · · · · · · · · · · · · · · ·
n n	permi Depa Impo any Ir		21. Signature of Funeral Service Lic Ronald S	Wade, D	irector		ate Anat	omy B	oard 65	5 W.	Baltimore	Street
-	_		23a Part Enter the disease or co	mulications that car	ised the death		altimore,		21201	iratory arres	et .	Approximate
			shock, or heart failure. List on	Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	Physician		Immediate Cause (Final disease or condition	_aE	ndsta	age	Deni	ntia				
	/Medical Examiner		resulting in death)	Due to (o	r as a consequ	ue <i>nde</i> of):						
	LAGITITICI		Sequentially list conditions.	b								
	ნ ≅	ner	cause. Enter Underlying	b. Due to (or an a consequence of): See Enter Underlying curse (Disease or injury								
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X Q Q	h cer andir use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna th 2 Feta		Ectopic pregnancy	,			23d. Date of d	
מ	death e atten ed for u	lcia	in the past 12 months?	4□Pregna	nt at time of de		Other (specify)				Month	Day Year
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Ţ	that hed b		Part II. Other significant conditions	contributing to dea	ith but not resi	ulting in the u	nderlying cause give	en in Part I	. 2	3e. Did toba	cco use contribute	to the cause of death?
cords	w requires that the diben signed by the should be detached	d by								1 ☐ Yes	2 No 3 1	robably 4 thisnown
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<u>0</u>	Attending in death. ector: After by the fune	atl	2 Accident investigat				M 1 🗆	Yes 2□	No			
DIVISION	r Att er de rect	ertification;	3 Suicide 6 Could not 4 Homicide determine	d 289. Place C	of Injury - At ho g, etc. (Specif	ome, farm, str	eet, factory, office			cation (Stre		Rural Route Number,
<u> </u>	To the Hospitel or Attendinition 24 hours after death. To the Funeral Director: A completely filled in by the fu	0										
	Hospitel 24 hours a Funeral tely filled	g	29a. Certifier Certifying Check only	hysician: To the base	est of my kno	wledge, deatl	n occurred at the tim	ne, date an	nd place, and du	e to the cau	ise(s) and manner	as stated.
	n 24 n 24 he F	edical	one)	and manne	er stated.	and and an	vestigation, in my o	piritori, dea	in occurred at t	ne une, uat	e and place, and do	te to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifie	1			29c. Licenso				d. Date signed (Mo	
			1/LMX				(1)	055	423		uno 2	8 2006
			30. Name and address of person wh	o completed cause	of death (Item	23a) (Type,	Print)		,	9		
			Ndidi Ferben				Ba	lto	md	212	1/2	8 2006
	Sta	ite	31. Date filed (Month, Day, Year)	32. Fr	gistrar's Signa	iture	1-4-					
	Regist	ar	JUL 03	2006	gistrar's Signa	B. B	DENE					
		-				0						

			For State	State of Maryland				Mental Hy	giene	5 20732
			Registrar 1. Decedent's Name (First, Middle, Las	1)	Certifica	ate of	Death	2. Date of De	Reg. No.	3. Time of Death
	Physicia /Medic	an al	ROBERT E.	MONTGOM				June	27° 2006	6:10 P. M.
	Examin	er	4a. Facility Name (If not institution, give	street and number) Whenical CEN	ni	ity, Town, o	r Location of De	eath	4c. County of De	eath .
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la		der 1 Year	If Under 24 H	Irs. 8. Date of Bir in. (Month, Da	rth 9. E	Sirthplace (State or Foreign Country)
	Director	4	220 • 34 • 443 1 1 Usuaf Residence of Decedent	2 F 67	Yrs.			10-25	5-38 M	ARYLAND
	yland how	.	10a. State 10b. County	10c. City	, Town or Location	•				10d. Inside City Limits
	8a-1 e	ector	MD HNNEHA	wudel G	EN BUR	NIE			40 000 4040	1 ☐ Yes 2 ☑ No
	within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23a or 28a-f ehow ha Madical Exam on must be motified at	Funeral Director	10e. Street and Number 133 CARROLL A	000	10r.	Zip Code	060		10g. Citizen of What	-
	ome 2	inera	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was De			(Specify Yes or No ento Rican, etc.)		nerican Indian,
36	rs after	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Mes 2 □ No	1 🗆 Va	2 No	Specify:	,	Specify:	ShiTE
21215-0036	2 hour	ted	15. Decedent's Ed		16a. Decedent's U	Isual Occup	ation	working	16b. Kind of Busines	ss/Industry
21	within 7 iene. than "r	Completed	(Specify only highest gra	Colfege (1-4or 5+)			during most of (d)	WOI KII 19	70.000	
N	filed v Hygie other t	e Co	17. Father's Name (First, Middle, Last)		TRUCK	DRI		Name (First, Middle	, Maiden Sumame)	ling
/lan	Mental Mental arked c	To Be	ELDON MONTO	SOMERY	,		HAZE	15.5	mith	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 23a or 28a-1 show important: If Item 27 is marked other than "naturel", or Items 23a or 28a-1 show any injury or other traumatic event, the Madical Examination must be notified at OREs.		19a. Informant's Name/Relationship (7	Type, Print)			01	. 0	er, City or Town, State	
	Health Hem 27 other tr	1	20a. Method of Disposition		ace of Disposition (in ametery, crematory)	Name of	D.GIEI	Date	20c. Location - City	
Ë	Pages nent of int: If it iry or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		HOMY BIFTS			-2-06	HANDVER	MD >
BaltImore,	permit. Pag Department Important: eny injury c		21, Signatura 11 Furth Service Licen		22. Name	and ddre	ss of Facility	I Home And Crei	mation Center, P.A.	
	40 = 4		23á. Part1. Enter the disease, of compshock, or heart failure. List only	plications that caused the death	2	2601	Mountain Ro	ad - Pasadena,	MD. 21122	Approximate
	Physician		shock, or heart failure. List only immediate Cause (Final disease or condition	one cause on each line M Per Las	comin.					Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):					
	Lxammer	-	Sequentially list conditions,	b. Zung	CONCELL sence of):					
	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. Chronic ob	structur	iN	mono	my des	ease_	
,092	ate be executed hysicien and his burial-transit		resulting in death) Last	Due to (or as a consequ	e e of):					
6876	physic s the b	dical		d						
Box (death certifica e attending ph id for use as th	In/Me	IF FEMALE: 23b. Was decedent pregnant	23c. ff yes, outcome of pregnal		c pregnancy			23d. Date of c	delivery
ю. В	es that the death certifica igned by the attending ph be detached for use as th	Physician/Medi	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of de 9□ Unknown					Month	Day Year
<u>α</u>	The law requires that the ite has been signed by thoge 2 should be detache	y Ph	Part II. Other significant conditions o	ontributing to death but not resu	ılting in the underlyin	ng cause giv	ven in Part I.	23e. Did	tobacco use contribute	to the cause of death?
Vital Records,	w requires been sign should be	ed by		· · · · · · · · · · · · · · · · · · ·				_ 1×	Yes 2□No 3□	Probably 4 🗆 Unknown
eco	law re nas be a 2 sho	Completed						24a. Was	psv prior t	autopsy findings available o completion of cause of
a H		e Cor	25. Was case referred to medical					1 Tes		es 2 No
ž.		To Be	examiner?	Hospitaf: 1 Inpatient 2	ER/Outpatient 3	DOA Ott	nor.	Death (Check only g Home 5 TRes	o <i>ne)</i> idence 6 ⊡Other (S _i	pecify)
n of	ng Ph ifter th		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at rk?		how injury occurred	
Division	Attending r death. ector: After by the fune	licati	2 Accident investigation 3 Suicide 6 Could not be		me farm street fac		Yes 2 □No	28f. Location	(Street and Number or	Rural Route Number.
Ş ≥	s after s after in Dire	Certification:	4 Homicide determined	building, etc. '(Specify)	nery, omoc			wn, State)	
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical (29a. Certifier 10 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examinat and manner stated.	wledge, death occur ion and/or investigat	red at the til tion, in my o	me, date and plopinion, death o	ace, and due to the ccurred at the time	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mo	
			15-72 lone	(m)		194	3977		June 2	7 2006
	1	M	30. Name and addr ss if person who	completed cause of death (Item	23a) (Type, Print)	ع (lo - A-	A Acad	MAD 210	1/21
		- 4	UMUR . U IVIII	1	ω ·	· / V	W D	Market 1	1400 Z 10	ושי

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Robert mongament

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			State	e of Maryland		iment of H			erie () () I	6 20733
	Dhysisia	_	1. Decedent's Name (First, Middle, Last)	. 1	00/11	7,000.0		2. Dete of Deet	h	3. Time of Death
	Physicia /Medica	al -	4a Fecility Neme (If not institution, give street end	d number)		4	b. City, Town, or Lo	cation of Deeth	4c. County of	
	Examine	er	CHRCY HOSPI				BACTI	RIFE	N/	
	Funeral Director		5. Social Security Number 6. Sex 217-24-4204 150 M 2	7. Age (In yrs. les 75		If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug. 31	, 1930 s	New York
-	/land	-	Usuel Residence of Decedent 10a. Stete 10b. County		Town or Loca					10d. Inside City Limits
	se-f et	cto	Md. N/A	Bal	timore				011111111111111111111111111111111111111	1 □XYes 2 □ No
	23a or 2	Funeral Director	1012 Stiles St.			10f. Zip Code 21202				JSA
036	al', o	اھ	1 Never Married 2 X Married 1 X I	Decedent Ever in U,S. d Forces? /es 2 □ No s, Give or Dates:		s Decedent of Hi es, specify Cuba	ispenic Origin? (Spe in, Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. Vhite
Baltimore, Maryland 21215-0036	be filed within 72 hours tal Hygiene. d other than "natural", event, ine Medical Exe	Completed			16e. Deceder (Give kir life. DC Brick	nt's Usuel Occupa nd of work done of NOT use retired Mason	ation during most of workii l)	ing	16b. Kind of Busi Constru	
d 21	e filed withi Il Hygiene. other than		10 17. Fether's Neme (First, Middle, Last)				18. Mother's Name	(First, Middle, M	Maiden Sumame)	
/lan	should be and Mental marked or numatic eve	To Be	Pasquale Manna				Mary	Tana		
Man	0 - = =		19a. Informant's Name/Relationship (Type, Print, Mrs.Anita M. Manna/ Wi		_	·	e <i>nd Number or R</i> ure t. Baltimo			lete, Zip Code)
ore, I	permit. Peges 1 and Depertment of Health Important: if item 27 any injury or other fr once.		20a. Method of Disposition	20b. Plac		ion (Name of tory or other plac		management of the comment		ity or Town, State
timo	permit. Pege Depertment of Important: if any injury or once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☑ Other (Specile/N tom	oment Most		Redeemen		-5-06		ore, Md.
Bal	permit Deper impor any in		21. Signature of Funeral Service Licensee			1050 You	ss of Fecility wson Funer rk Rd. To	wson, Mc	1. 21204	
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	hat ceused the deeth. on each line.	Do not enter	the mode of dyin	g, such as cardiac c	or respiratory arm	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition	MPHI	452	MA				VR5
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of Vital Records,	The law requires that tha death certificate be assecuted ate has been signed by the attanding physicien en: A paga 2 should be detached for use es the burial-transit	Completed by Physician/M		/				24a. Was a perform		24b. Were autopsy findings available prior to completion of cause of deeth?
l Re	Physician: The law r this certificate hes aral diractor, paga 2	Eo						1 🗆 Ye	es 2000	1 ☐ Yes 2 ☐ No
Vita	Physician: this certific ral diractor,	o Be	25. Wes cese referred to medical exeminer?	Managing 005	R/Outpetient	a□ po₄ Oth	26. Plece of Death		e) ence 6 ⊡Other	(Facility)
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Division	To the Hospital or Attending Phywithin 24 hours effar deeth. To the Funeral Director: After thi completely filled in by tha funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. I	Plece of Injury · At hom building, etc. (Specify)	ne, farm, stree	t, factory, office		28f. Location (Si City or Town		or Rurel Route Number,
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	To the within To the compl	Me	29b. Signature and title of certifier	\sim		29c. Licens	e number	4 2	9d. Date signed	(Month, Dey, Year)
			1005/ Cost) / / L	Ogal (Tura D	y y	1262	1	July	1,000
	5+1		30 Name and eddress of person who completed	Sul S	T P	ALL P	THE	BAUTI	rore,	20212 CM
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:30 P^M June 27, 2006 Margaret Hartsfield McHugh /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Crofton Anne Arundel Crofton Convalescent & Rehabilitation 7. Age (In yrs. last birthday) If Unou If Under 1 8. Date of Birth (Month, Day, July 28 5. Social Security Number **Funeral** Days Hours Min. 1 □ M 2 K F Yrs. 89 Director 401-07-9527 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than *natural', or iteme 23a or 28e-f show any injury or othar traumatic event. If a Moulcal Exarcher must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☑ No Funeral Director Pasadena Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21122 754 218th Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: ģ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Gov't Employee 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Josephine Karlen Hartsfield Benjamin ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 754 218th Street, Pasadena, MD 21122 19a. Informant's Name/Relationship (Type, Print) (son) Thomas McHugh 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 3 2006 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Richmond, Virginia Calvary Cemetery 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Funeral Service License 3111 Mountain Road, Pasadena, MD 21122 23a Part I Enter the disease, or confplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 700 **Physician** /Medical Due to (or as a consequence of). Deellia Examiner sequentially list conclusions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events of (or as a consequence of). Examine leere attending physician and death certificate be executed resulting in death) Last o (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has performed 1 Yes 20 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital: Other: Wursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1 ⊟Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a, Certifie 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the e of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe JI of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day) Year) 32 Registrar's Signatu State Registrar 2006 03

State of Maryland / Department of Health and Mental Hygienery 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:00 AM /Medical 4a. Facility Hame (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Healthcare MORC If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 2230 215-42-11,1942 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or iteme 23a or 28a-1 show the Wedical Examinar must be notified at 1 ☐ Yes 2 No Funeral Director ton Maryland 1-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Aberdeen 21114 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Heelth and Mental Hygiene. Item 27 is marked other than other traumatic event, the Market traumatic event, the Market traumatic event, the Market traumatic event, the Market traumatic event, the Market traumatic event, the Market traumatic event, the Market traumatic event, the Market traumatic event, the Market traumatic event eve Elementary/Secondary (0-12) College (1-4or 5+) Auto Sup SALESMAN 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Esther Meisc ဥ tenn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OWSON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of importent: If eny injury or page. Baltimore, MARYLAND Ay VIRW Crema fory Tre DULY 1, 2006 4 □ Donation 5 □ Other (Specify) 21. Signature of Puneral Service Licensee LICENSED MORTICIAN Balto Maryland 212/4 ROND HATFORD dispess, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tadure. Ust only one cause on each line. Approximate Interval Between Onserand Death 23a. Part 1. Enter the diseas shock, or heart failure. tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospitai or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 24010 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending nerel Director: A 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 185 who completed ause of death (ftem 23a) (Type, Print) GOYM 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For Stata Ragistrar Certificate of Death Rag. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2006 12:30 June 30 <u>Frances</u> A. Plichta /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Baltimore Good Samaritan Nursing Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1/15/ Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Months 1 M 258 F Virginia West Director 233-34-0116 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County is than "natural", or Itams 23e or 28e-f show the Medical Examines must be nedified at 1 X Yes 2 ☐ No Baltimore Directo MD n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21224 Street 503 S. Potomac Completed by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify If Yes, Give Year or Dates: White 3 N Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Flementary/Secondary (0-12) College (1-4or 5+) Retail Retail Sales 0 12 traumatic avant. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Int: If itam 27 Ia marked o Mary Mazzei Umberto Iaconis ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21014 Bel Air, Md. 603 Churchill Rd. Unit G Bernadette Plichta Daug. other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5 Department of Important: If any injury or once. Baltimore, Md. Stanislaus 7/5/06 · 4 □ Donation 5 🛭 Other (Eperty ombment St. Karerer owski facili Juneral Home P. A. 21. Signature of Funeral Service Lice 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can be each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-transit and ue to (or as a consequence of) Box 68760, attending physician for use as the burial Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed b d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 robably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 2 ₩ No 1 ☐ Yes 2√2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Nursing Home 1 Inpatient 2 ihis 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After the Hospital or Attanding Injury 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 No death. after death Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide hin 24 hours a tha Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within To tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D38033 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe South Highland Ave. Baltimore, 261 \mathbf{F} . Ibarra, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0

		-	For State of Maryland	d / Department of Health and Certificate of Death		ene2006 2073/
	_		Negistrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici		Barbara Marie Pippin		Month	Day 2806 6" 04PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	ith	4c County of Deatho,
			Flanklin Squalet	ospita Rosedal	6	Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (<i>In yrs. la</i> 2 ☐ F 5.6	ast birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day,	Year) 9. Birthplace (State or Foreign Country) , 1949 Marykand
	Director		215-54-2015 1 M 2 XF 56	TIS.	Dec. 12	, 1949 Marykand
	and and	-		, Town or Location		10d. fnside City Limits
	the Marylar 28a-f show notified at	ğ	Maryland Baltimore	Perry Hall		1 ☐ Yes 2 🔯 No
	1 the	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
)	h with	<u>E</u>	17 C Brook Farms Court	21128		U.S.A.
\Diamond	after death with the Maryla or Itsms 23s or 28s-f shov miner must be notified at	ner	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 	Specify Yes or No- into Rican, etc.)	14. Race - American Indian, Bfack, White, etc.
98	or It	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No If Yes, Give 3 ☐ Widowed 4 💆 Divorced Year or Dates:	1 ☐ Yes 2 【 No Specify:		Specify: White
ರ\$	within 72 hours after death with the Maryland ane than "natural", or Itama 23e or 28e-f show the Madical Examiner must be notified at	q pa	3 ☐ Widowed 4 ☒ Divorced Year or Dates:	16a. Decedent's Usual Occupation	1	6b. Kind of Business/Industry
<u>-</u>	in 72	piet	(Specify only highest grade completed)	(Give kind of work done during most of we life. DO NOT use retired)	orking	
212	y with	E	Elementary/Secondary (0-12) Colfege (1-4or 5+)	Receptionist		Rockport Shoes
Q E	be filed ntal Hygie od other svant, II	Be Completed	17. Father's Name (First, Middle, Last)		ame (First, Middle, M	
a	2920	10	Maurice L. Pippin, Sr.		Le M. Wol	
<u>~</u> <u>~</u> <u>~</u> <u>~</u> <u>~</u> <u>~</u> <u>~</u> <u>~</u> <u>~</u> <u>~</u>	d 2 shou th and M 7 Is mar treumati		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or F		
0 0°	s 1 end 2 of Heelth Itsm 27 other tre		Lucille M. Pippin (mother) 20a. Method of Disposition 20b. Pi	17 C Brook Farms Ct.		ACC. MV 21128 20c. Location - City or Town, State
وَ	of of or		1 Liburial 2 Algermation 3 Libermoval from State 1	ace of Disposition (Name of emetery, crematory or other place)		Baltimore, Maryland
Kin .			4 Donation (Other (Specify) Bay 21 Signature of Finish Service 1 See	yview Crematory $17/6$, 22. Name and Address of Facility S		
Balt	permit. Depertm Imports any Inju		Sim Banant.	9705 Belair Rd.,		
			23a. Part. Enter the disease, or combications that caused the death shock, or heart failure. List only one cause on each line.	i. Do not enter the mode of dying, such as cardi	ac or respiratory arre	Interval between
	Physician		Immediate Cause (Final disease or condition	P.E.		Onset and Death
	/Medical		resulting in death) Due to (or as a consequence)	uence of):		
	Examiner	-	Sequentially list conditions, b. Due to for as a non-equ	s transfer of the fi		
V	led Isit	nine	cause. Enter Underlying Cause (Disease or injury	idi ni di Viji		
V	cate be executed physicien and the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of the consequence).	zence of):		
8760,	physicient the burn	dicail	d			
9	rtifica ng ph as th	Medi	IF FEMALE:			
Вох	eath certifii attending (an/h	23b. Was decedent pregnant 1 Live birth 2 Fetal	I death 3 Ectopic pregnancy		23d. Date of defivery Month Day Year
	The law requires that the death certifi ste has been signed by the attending page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 Ø No 9 ☐ Unknown	eath 5 Other (specify)		
P.O.	ires that the de signed by the a d be detached t		Part II. Other significant conditions contributing to death but not resi	ulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to the cause of death?
,sp	uires n sign	d by			1 □ Ye	s 2 No 3 Probably 4 Unknown
loo	w requir s been si should	Completed			24a. Was ar	n 24b. Were autopsy findings available
Re	hysician: The law his certificete has t I director, page 2 s	E			autops perform	
ital		BeC	25. Was case referred to medical	26. Pface of D	eath (Check only on	
>	Physician: this certific ral director,	10				nce 6 Other (Specify)
0	□ = 'a	Ë	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year)	28b. Time of Injury at Work?	28d. Describe ho	w injury occurred
Si Si	tendi Jeath tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be 289 Place of Injury - At by	M 1 ☐ Yes 2 ☐ No	28f Location /Str	reet and Number or Rural Route Number,
Division of Vital Records,	after of Direct	Certification:	4 Homicide determined building, etc. (Specifi	/)	City or Town	
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 12 Certifying Physician: To the best of my kno			
	ha Ho in 24 i ha Fu pletely	edical	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.			
	With To t	Σ	29b. Signature and title of certifier	29c. License number	_	9d. Date signed (Month, Day, Year)
			earner france	900 33373		01/01/006
	10		30. Name and address of person who completed cause of death (Item	DOF CONKLIN SOLL	ase Dri	re Baltimore, MDaD3
	St	ate	31. Date filed (Month, Day, Year) 32. egistrar's Signa	the Sparke	- 1 V	The state of the s
	Regist	irar	JUL 0 3 2006 Status	U DESTRUCTION		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year PARSON 14:35 PM **Physician** 3 ELIZA BETH 06 2 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ohns ocial Security Number MOTE If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. ast birthday) **Funeral** Min Months Days Hours Marylana 18-3039 1 ☐ M 2 1 F Yrs. Jan.6. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show the Mudical Examiner must be notified at 1 XYes 2 No Maryland Director more 28e-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 21 a 238 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, Race or items 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 X Widowed 4 Divorced "netural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) pernit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important; if item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pfint) daughter ViKita 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State ö 12006 FreenMount Crematory njury 22. Name and Address of Famility 21. Signature of Funeral Service Licenses P.A. eny r tomer. Joseph Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart fellure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) JOAV S **Physician** ATHROSCLENOTIC D RONANON /Medical Due to (or as a consequence of): Examiner 44 PERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ate hes been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Denknown Completed 24b. Were autopsy findings available prior to completion of cause of death? After this certificate hes autopsy performed 2 1 No 2 No 1 Yes To the Hospitel or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) Hospital: 2 DER/Outpatient 1 □ Yes 2 □ No 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification; 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number

State Registrar

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3 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LANG

31. Date filed (Month, Day, Year) 2006

State of Manyland / Department of Health and Mental Hygiene 2 0 0 C

			For State Registrar	State of Ma	-	partment of H		rental mygle Reg	local Gr Gr Gr	20733
ı			Decedent's Name (First, Middle, Last,)				2. Date of Death Month	_	3. Time of Death
	Physicia /Medic		FREDERICK	PAU	SCH			JUN	2006	, 1150 AM
	Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or			4c. County of Deat	
			Howard County Gen			Colu			Howard	
	Funeral		5. Social Security Number 6. Se	714 00 5	(In yrs. last birthd	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birt	thplace (State or Foreign ountry) yland
	Director		217-18-6396 Usual Residence of Decedent		0.3			NOV /, I	722 Mai	ylanu
	yland		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	8a-f	cto	MD Howard		Co1u	ımbia				1 ☐ Yes 2√☐ No
	vith th	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
	ss 23s	erai	9441 Dartmouth Roa	ad 12. Was Decedent B	Ever in U.S.	210		acity Yas or No-	USA 14. Race - Ame	arican Indian,
22	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. I and Mental type files and set other than "natural", or Items 23s or 28s-f show aumstic event, the Modical Examinar must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ∑Yes 2 □ N If Yes, Give Year or Dates:	10 142-46	 Was Decedent of His If Yes, specify Cubar Yes 2√√2 No 	Specify:	Rican, etc.)	Black, Whit	e, etc.
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7	Hygie Hygie ther t		12 17. Father's Name (First, Middle, Last)	5		manager	18. Mother's Name	e (First, Middle, Ma	<u>insuran</u> iden Sumame)	ce
Ē	d be f	o Be	Frederick Ernest F	ausch?			Marjorie	⊇ Joy Rob	inson	
<u></u>	shoul nd Me mari	To	19a. Informant's Name/Relationship (T)	ype, Print)	19b. M	lailing Address (Street a				Zip Code)
Ž	alth a alth a 27 le		Virginia Pausch/s	pouse	944	41 Dartmout	h Road Co	olumbia, 1	MD 21045	
ballillore,	permit. Pages 1 and 2 should be Department of Heatilb and Menta Important: If Item 27 is marked any injury or other traumatic ev <u>once</u> .		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify,			isposition (Name of crematory or other place		Date 20	c. Location - City or	Town, State
סמור	permit. Departn Importe any inju		21. Signature of Funeral Stryice Licens Ronald S.	Wade, Dire	ector	State Anato Baltimore,			altimore	Street
	Physician		23a. Part L. Enter the disease, or comp shock or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each lin	the death. Do not		g, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of)					
	suted Id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence of)					
00/00	ificate be executed g physicien and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as a	a consequence of)					
-	tifical ng ph as th		15 55 W 15							
C. BOX	death cer e attendir d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 Ectopic pregnancy 5 Other (specify)			23d. Date of de Month	livery Day Year
ds, r.	requires that the een signed by th nould be detache	þ	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in th	ne underlying cause give	en in Part I.		1	o the cause of death?
Hecords	The law req ste has beer pege 2 shou	Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
VITAI	ician: Th certificete rector, peg	0	25. Was case referred to medical				26. Place of Deat	h (Check only one)	3110	
	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outp	atient 3 DOA Other	4 Linuising ac	ome 5 Resident	ce 6 □Other (Spe	ecify)
n or	Ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry Yea <i>r)</i> 28b. Tin y Yea <i>r)</i> Inju	ıry Worl		28d. Describe how	injury occurred	
200	or Attending Physician: after death. Director: Atter this certific in by the funeral director.	Icat	2 Accident investigation 3 Suicide 6 Could not be		uny - At home, farm	M 1 []	Yes 2 □ No	28f Location (Stre	et and Number or R	ural Boute Number
DIVISION	l or Attendation after deati	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	i, stroot, factory, office		City or Town,		ara. r. oato rranios,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	ledical C			examination and/	death occurred at the tin or investigation, in my o				
	within To the	Me	29b. Signature and title of certifier	10		29c. License	e number	290	I. Date signed (Mon	th, Day, Year)
)			Jan 11	hles r	10	D	5665	1 3	Tune 2	7 2006
			30. Name and address of person who o					10	1170	
			31. Date filed (Month, Day; Year)	8186 Lon			vicinge , N	N2 S	1015	
	Sta Regist	ate rar	JUL 0 3 200	6 Care	ar's Signature	parte				

DHMH 17 Rev 1/2001

			For State of Ma		epartmen Certificat				giene	006	20740
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	V	3. Time of Death
	Physicia		Albert Edward Sikorsky, Jr.					Month	Olay	2006	15:07p M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City	Town, or Lo	cation of Death		4c. Co	unty of Death	- 00
			Franklin Sallare Hos	atal	1	Lose	ame		B	alti	noie
	Funeral		,	(In yrs. last birth	Months		f Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Date Sept. 1 (h y, Year)	9. Birth Cou	place (State or Foreign ntry)
	Director		212-32-0033	72 Yr	S.			Sept.10	1933	Mary	land
	and w	-	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town o	or Location						10d. Inside City Limits
	Maryla F sho	ō	Maryland Baltimore	Essex							1 □ Yes 2√2 No
	death with the Maryland oms 23e or 28a-f show ir outst be natified at	Director	10e. Street and Number	100011	10f. Zip	Code			10g. Citizer	of What Cou	intry?
	with se or	<u> </u>	306 South Woodward Drive			21221			U.S.	Α.	
	death ms 23	Funeral	11 Maritat Status 12. Was Decedent E	ver in U.S.	13. Was Dece		anic Origin? (Sp Mexican, Puerto	ecity Yes or No		Race - Amer	
<u>_</u> 9	or Iter		Armed Forces? 1 □ Nøver Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	lo	if Yes, spe		Specify:	nican, etc.)		Black, White	
33		à b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Korea	1 🗆 163	22,10				M	hite —————
1) DC	72 hours "natural", dical Ext	Completed	 Decedent's Education (Specify only highest grade completed) 	(ecedent's Usu Give kind of wo	rk done dur	on ring most of work	ing	16b. Kind	of Business/I	ndustry
12	C 508	I I I	Elementary/Secondary (0-12) College (1-4or 5	+)	_{ію. Do NOT u} countar				Acc	countin	na
2	iled v Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)	AC	countai		8. Mother's Nam	e (First, Middle,			-9
aryland	should be filed within and Mental Hygiene. ie marked other than eumatic event, the Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Men	o Be	Albert Edward Sikorsky			м	arqueri	te Wvati	E		
S	shoul nd Me mark	၉	19a. Informant's Name/Relationship (Type, Print)	19b. I	Mailing Addres		d Number or Rur	_		own, State, Zi	ip Code)
\(\sigma_\sigma	nd 2 state at the tree		Ethel Sikorsky (Wife)	30	6 South	n Wood	lward Dr:	ive, Es	sex, N	Marylar	nd 21221
₹ ē.	S 1 and Head Item		20a. Method of Disposition	20b. Place of Cometery	Disposition (Na.	me of other place)		Date	20c. Loca	tion - City or T	own, State
, ~ E	Page tent o nt: If		1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)					6,2006	Balti	imore,	Maryland
altimore	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than eny injury or other treumatic event, tha Monce.		21. Signature of Forman Service Licensee		22. Name a	nd Address Bru	of Facility 12d21nsk	i Funera	al Hor	ne, P.A	٨.
•	89558	0			140/	OTO F	astern .	avenue,	Essez	k, Mary	Tana Zizzi
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do no	t enter the mo	de of dying,	such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	= Myou	cardi	al	Lnfar	CHOC)		Orisbi and Death
	/Medical Examiner		resulting in death) Due to (or as	a consequence of	11	~).000	OA			
	LAdiffile		Sequentially list conditions, if any, leading to immediate	a consequence of	4rrei	4	VISCU	20			
-	ed salt	Examiner	cause. Enter Underlying Cause (Disease or injury	a consequence of	<i>)</i> .						
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	ificate g phy as the	edic									
ŏ	eath certiff attending for use as	M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	of pregnancy 2 Petal death	3 ⊟Ectopic p	nregnancy			230	d. Date of deli	•
Ď.	es that the death certific Igned by the attending P be detached for use as	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at		5 ☐ Other (s			-		Month	Day Year
0.	at the	ار گر	9 LUnknown					DO Did			the cause of death?
Division of Vital Records, P.O. Box 68	or Attending Physician: The law requires that the death certifica ster death. Director: After this certificate has been signed by the attending pt in by the funeral director, page 2 should be detached for use as the	5	Part If. Other significant conditions contributing to death b	ut not resulting in	the underlying	cause giv <i>e</i> n	in Paπ I.	1	N. 4	1	
ord	law requir as been s 2 should	Completed									
ě	elaw hasb)e2si	dr.						24a. Was auto	an psy ormed2	prior to death?	topsy findings available ompletion of cause of
<u> </u>	ician: The certificate ector, pag							1 □ Yes	2 No	1 ☐ Yes	2□ No
V.	tending Physician: The leath. leath. tor: After this certificate ha the funeral director, page	Be	25. Was case referred to medical examiner? Hospital:	ent 20 ER/Out		Other	26. Place of Dea	th <i>(Check only c</i> om <i>e</i> 5 □ Resi		TOther (Case	
of	Phys rthis ral di	5.	1 Yes 2 No 1 Inpatie 27. Manner of Death 28a. Date of Inju (Month, Da		me of	28c. Injury a	4 🗀 1401 3111g (1)	28d. Describe			ary)
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	To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completely filled in by the		29a. Certifier Certifying Physician: To the best Medical Examiner: On the basis of	of my knowledge, f examination and	death occurred for investigation	d at the time	e, date and place nion, death occur	and due to the	cause(s) as date and p	nd manner as lace, and due	stated. to the cause(s)
	the H the F the F mplet	Medical	one) and manner st 29b. Signature and title of certifier	ated.	20	ec. License	number		29d Date	signed (Monti	Day Year)
	7 × 0 0		29b. Signature and title of certains	ton		nn	2587	£1		11/	
	141		20. Name and address of person who completed cause of	leath (Item 23a) /	(vpe. Print)				,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July 2, ^{Day} 2006 1:00 P M **Physician** EILEEN McLAUGHLIN SMITH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore County STELLA MARIS HOSPICE Timonium If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 3, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F 90 Yrs. Maryland Director 212**-**10-8160 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Timonium Maryland | Baltimore County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 2300 Dulaney Valley Road 21093 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Ites 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White à 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper 12 yrs Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Marie Francis Joseph McLaughlin O'Niell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Pine Chip Court, Baltimore, MD 21236 Diane T. Cimino (Dau hter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If any Injury or once. 4 Donation 5 Other (Specify) 7/7/2006 Parkwood Cemetery Parkville, Maryland 21. Signature of Fundal Savin Licensee Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finat Vascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 210 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation I Diractor: A 1 ☐ Yes 2 ☐ No death. 6 Could not be 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/3/2006 2300 Dulaney Valley RD Timonium, MD 21093

Registrar DHMH 17 Rev 1/2001

State

laria 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahmood,

32 Registrar's Signature

		State of Maryland / Department of Health and M		_			
		For State of Maryland / Department of Health and W		2006	20742		
		Decedent's Name (First, Middle, Last)	2. Date of Death Month		3. Time of Death		
Physici /Medic		MARY CASSIA SCHNEIDER	June	29 Year	6 6:50A [™]		
Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea			
		Maria Health Care Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Baltimore Sight On Birtheless (Chair on Foreign			
Funeral Director		149-42-5398 1 Months Days Hours Min.	8. Date of Birth (Month, Day, Y Dec. 23, 1	913 Pen	hplace (State or Foreign nuntry) NSylvania		
Pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
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28a-	rect	Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code	100	. Citizen of What Co			
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er dea	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit			
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Hygier than the	Co		e (First, Middle, Ma	Parochia	1 201001		
d be ental ked o	To Be		a Stoll				
Tary 2 shou and M is mar	j- -	19a. Informant's Name/Relationship (Type, Print) S. Bernice Feilinger SSND 19b. Mailing Address (Street and Number or Run 6401 North Charles Street					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan popartment of Health and Mental Hygiene. Important: if them 27 is marked othar than "natural; or itams 23a or 28a-1 show any injury or othar traumatic event, the Madical Examinar must be notified at once.				c. Location - City or			
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Salti sermit. epartn oporta vy inju	0	21. Name and Address of Facility Mit C					
m goesa		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate		
THE PARTY OF		shock, or heart failure. List only one cause on each line. Immediate Cause (Final End Stage CUE/CODD	or respiratory arres	.,	Interval Between Onset and Death		
Pnysician /Medical		disease or condition resulting in death) LINU Stage CHIP/COPD a. Due to (or as a consequence of):					
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Box eath cer attendin for use	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (specify)		23d. Date of de Month	ivery Day Year		
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(0)	To B	examiner? 1 Yes XXNo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: XX Nursing Ho	me 5 Residen	ce 6 □Other (Spe	cify)		
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Division al or Attendir s after death. al Diractor: At	Certification;	4 ☐ Homicide building, etc. (Specily)	City or Town,	State)			
DIVIS To the Hospital or Atte within 24 hours after def to the Funeral Directe completely filled in by th	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated—and manner stated—	and due to the cau red at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)		
To the To the Comple	Me	29b. Signature and title of certifier 29c. License number	290	I. Date signed (Mont	h, Day, Year)		
		Mana X Convell D0001373		June 29	2006		
1		30. Name and address of person who completed cause of death (Item 23a) (The Print) Francis X Carmody, M.D. 7505 Osler Drive Towson, Maryl	and 2120	4			
	ate						
Regist	rar	31. Date filed (Month, Day, Year) 32. Distrar's Signature JUL 0 3 2006					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [State Registrar Amend #4c Per PHy G857 7/06/09 rtime ate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 6 **Physician** tokes 0 fizabet 2000 /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner ucton Raltimore. If Under 24 Hrs. Birthplece (State or Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 8 Days Hours -28-156 1 ☐ M 2 💢 F Director Usuel Residence of Decedent Pages 1 and 2 should be filled within 72 hours atter death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, It e Medical Evaruit as must be rectified at 1 ☐ Yes 2 ☐ No Directo Pikesville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 USA 7 Sudbrook Lane Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Parks Sausage Inc Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Captolia Alston Waverly Edmond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 10 N. Calvert Street Baltimore, MD <u>Cassandra Lucas/guardian</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite ony injury or ot once. 1 Buriai 2 Cremation 3 Removal from State `4 □Donation 5 ☑Other (Specify) in state 21. Signature of Funeral Service Licensee Konald S. Wade, State Anatomy Board 655 W. Baltimore Street Director mu Baltimore, MD_ 21201 mer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 1Pars resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 18No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown been (24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has certificate 1 ☐ Yes 2 🖾 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Mo 2 2 ER/Outpatient 3 DOA this filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Matural М 1 Yes 2 No 2 Accident after death Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Jef Zoboll MD June 76, 7006 30. Name and address of person who completed cause of de hb (Item 23a) (Type, Print)

State Registrar

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31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Teitelbaum, M.D. Ph. D. 12:40P M 2006 Harry Allen 30 June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1190 W. Northern Parkway #317 Baltimore 8. Date of Birth (Month, Day, Year) Oct. 7, 1907 5. Social Security Number 215-32-9054 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours New York 1 □XM 2 □ F 98 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count 23a or 28a-f ehow the Medical Examiner hast be notified at Baltimore Md. N/A 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21210 1190 W.Northern Parkway #317 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? type yes 2 □ No if yes, Give Year or Dates: 14. Race - American Indian. iteme Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 5 White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. <u>ک</u> 3 ♥ Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Medicine permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient Important: If Item 27 is marked other the eny injury or other treumatic event, Italy 2002. Physician 5+18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gitel Levine Louis Teitelbaum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Paul S. Teitelbaum/ Son 1190 W. Northern Pkwy #317 Baltimore, Md. 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-3-06 Hilltop Service Co. Towson, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atherosclerotic conditionsalin Immediate Cause (Final disease or condition resulting in death) Pnysician J 38 ones /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (un as a collisequence of) Examine or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, signed by the attending physician be detached for use as the buria Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 EYes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 1 No 1 Yes 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funaral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified June 30, 2006 wo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Bolts and 2120x Bino 6701 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 0 3 2006 Cook Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:48 AM **Physician** Micheal lakw: 2006 24 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give, street and number) Examiner Baltimore Medical 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** MI) Vrs N Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat countried at once. 1 Yes 2 No Completed by Funeral Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number MINDALE CIRCLE 21244 USA 8307 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 () 2 1 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 22No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INFANT 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TAKWI UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TAKWI - MOTHER 8307 MINDALE CIRCLE APT B BALTIMORE MO 21244 BILL 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 130/06 en/ timore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tadley -ASKONF.H., D.A 21. Signature of Funeral Service Licensee STOLING 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prematu! 1 Extreme **Physician** /Medical Due to (or as a consequence of). Examiner Signer tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Yeone ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Syndrome Resilieton dis Kess 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ... I neumom 24a. Was an autopsy performed? Anemia Yes 25 No 2**V** No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month, Day, Year) JUL 0 3 2006

29b. Signature and title.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fernance Mena 301 St PAUL Place 32. Registrar's Signature

MI)

ORIGINAL

29c. License number

29d. Date sign (Month, Day, Year)

24/06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 2006 **Physician** June 24, Underwood 11:30 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bel Air 4c. County of Death Examiner Harford Bel Air Health & Rehab If Under 24 Hrs. 8. Date of Birth May 14, 1918 5. Social Security Number If Under 1 Year 6 Sex 7. Age (In vrs. last birthday) 9 Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 □ F Hours Min. Germany Yrs. 88 Director 215-36-9001 Usual Residence of Decedent ie filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or Iteme 23a or 28e-1 ehow 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Item 27 is marked other than "natural", or Iteme 23a or 28e-1 ehow other treumstic event, the Medical Exempter must be additived at Bel Air Harford Md. 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21009 3326 Berlin Court Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) bakery baker 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be r is marked of should be unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3326 Berlin Court, Abingdon, MD 21009 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n Hans Underwood/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 € Cremation 3 ☐ Removal from State ō 6/27/2006 Baltimore, Md. Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) injury 21. Signature of Fungral Sovice Licenses 22. Name and Address of Facility any ir Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and 21014 Approximately, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cerebrovascular accident disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): physicien Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 8 oropharyngeal dysphagia 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed pneumonia 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes **No 24a. Was an clostridium difficile colitis 1□ Yes 🛠 🗆 No Physician: after death.

Director: After this certific
I in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: Certification; To 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Hospitel or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my Knowledge, death occurred at the time, date and place, and due to the cause(s) and markets as states.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

14 State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Manuel M. Lazatin, M.D., 8 Law Street, Aberdeen, Md. 21001



D19583

June 24,2006

Physician	For State Ragistrar Decedent's Name (First, Middle, Last)			rificate of l		Mental Hyg	2111	06 2074
Physician	. Decedent's Harno (1 mai, middle, East)		Cert	incate or i	Dealii	2. Date of Dea		3. Time of Death
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/iviedical	Ralph a. Facility Name (If not institution, give st			4b. City, Town, or	r Location of De		4c. County	
L AUITIU CI	Bayview Medical			Baltimo		401	N/A	
5	Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year	If Under 24 H	rs. 8. Date of Birtl	h	Birthplace (State or Fore Country)
Director		M 2□F 87	Yrs.	Months Days	Hours Mi	Dec 8,	1918	Pennsylvan
lanow 10	0a. State 10b. County	10c. City	, Town or Loca	ation				10d. Inside City Lim
be tiled within 72 hours after death with the Maryland stal Hygiene. d other then "natural", or Items 23a or 28a-f show event, the Modical Examinational be notified at Be Completed by Funeral Director	MD Anne Aru	ndel /	Arnold					1 ☐ Yes 2 🗷 N
h the	0e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
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deat ner	1. Marital Status	Was Decedent Ever in U. Armed Forces?	S. 13. W	as Decedent of H	lispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race Blace	e - American Indian, k, White, etc.
or its	1 Never Married 2 Married	1 Yes 2 No If Yes, Give	1	☐ Yes 2M No		,	Specify	
raf.	3 ☑Widowed 4 ☐ Divorced	Year or Dates:			орозија			White
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2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the M	12		Prop	rietor	10 Matheric N	ame (First, Middle,		Hanging
tal H doth	7. Father's Name (First, Middle, Last) Dominic Viola					ina (unk		₽/
should be to the total be to t					0			0 7. 0.44
2 sho	19a. Informant's Name/Relationship (Type Kristine Lowe-		19b. Mailing	i Address <i>(Street</i> Juena V	and Numberor ista Av	Rural Route Numbe Ve. Arno	or, City or Town,	State, 210 Code)
ges 1 and 2 should t of Health and Mer if item 27 is marks or other traumatic			lace of Dispos		1500 11	Date		City or Town, State
T to to to to to to to to to to to to to	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 至Re	amount from State	emetery, crem	atory or other plac				•
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Dep Impo	21. Signature of Funeral Service License Turnet 23a, Part1. Enter the disease, or complice	lachs	12	01 Duno	dalk Av	ve. Balt	imore,	eral Home, MD 21222
/Medical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease) or injury that initiated events resulting in death) Last	Thermal Ir Due to (or as a consequence of the conse	uence of): uence of):		/- //	ications		Onset and Death
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			1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month		/	3. Time of Death
	Physici		Amalia Vazquez	JUNE		_{7 еаг}	12:20 X
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	h	4c. County of	Death	
			GREATER BALTIMORE MEDICAL CENTER TOWSON			TIMO	RE
	Funeral Director		5. Social Security Number 6. Sex 1 DD - D3 - D669 6. Sex 1 M 2 F 92 7. Age (In yrs. last birthday) Months Days Hours Min.		, 1913	Count	ace (State or Foreign ry) to Rico
_	ehow	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Md. Baltimore Timonium		· · · · · · · · · · · · · · · · · · ·	10	d. Inside City Limits 1 ☐ Yes 2 🔀 No
19.	hours after death with the Maryland turel', or flems 23a or 28a-f ehow al Examiner must be notified al	Funeral Director	10e. Street and Number 10f. Zip Code 2525 Pot Spring Rd. S-324 21093	1	0g. Citizen of Wh	nat Count	ry?
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16 Z	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturent properties on Item Musical eny Injury or other traumatic event, the Musical	To Be		me (First, Middle, M			exiera
Man Man	id 2 sho lth and 1 27 is ma traums		19a. Informant's Name/Relationship (Type, Print) Mrs. Esther Rossello/ Cousin 19b. Mailing Address (Street and Number or R. 2525 Pot Spring Rd. 9				
	of Heal		20a. Method of Disposition 1 \times Burial 2 \(\times Cremation \) 3 \(\times Removal from State \) 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - C	City or Tox	vn, State
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	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	c or respiratory arre	est,		Approximate Interval Between Onset and Death
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	ransit	Examiner	Sequentially list conditions, if any, feading to announce of the cause. Enter Underlying Cause (Disease or injury				
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P.O. Box 68	eath cer attendir for use	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ★ 20 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date Mon		ry Day Year
G.	puires that		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	/		e cause of death?
Division of Vital Records.	The law red te hes bee age 2 shor	Completed		24a. Was a autops perform	med? pr	ior to con	esy findings available inpletion of cause of
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>	nysic nis ce	To		Home 5 ☐ Reside	ence 6 Othe	r (Specify)
ם מ	ding Pf th. : After the	itlon:	27. Manner of Death 1	28d. Describe ho	ow injury occurre	d	
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	To the within ?	Mec	29b. Signature and title of certifier 29c. License number	_ 2	9d. Date signed	(Month,	Day, Year)
	6		30 Name and address of person who completed cause of 19th (Item 23a) (Type, Print)		0/30	5/6	usser sons 2026 9
1		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	s stream	Bartio	udf e	20264
	Regist	rar	JUL 0 3 2006 Reports				/

			For State Registrar		State of	Marylar		artment of F		ind Menta	l Hygie	7 1111	20749		
	Physicia	an	1. Decedent's Name (F		ist)					Mos	of Death ath	Day Year	3. Time of Death		
H	/Medic	al	ANGELINE V		a street and sum	harl		4b. City. Town, o	v I conting of	Jul	y o	4c. County of Dea			
	Examin	er	4a. Facility Name (If no				ntel	Glen	Buri	04	,	1 1	rundel		
	Funeral		Social Security Num	ber 6.	Sex 7	. Age (in yrs.	last birthday)		If Under 2		of Birth onth, Day, Ye Y 29,	9. Bi	rthplace (State or Foreign		
Е	Director		220-20-2362 Usual Residence of De	_	1 M 2 LEDEF	76	Yrs.			JUL	Y 29,	1929 MAI	RYLAND		
	yland		10a. State 10	Ob. County		10c. Ci	ty, Town or Lo	ocation					10d, Inside City Limits		
	e Mar	ctor	MARYLAND A	ANNE AR	UNDEL	GLE	N BURN	I.E					1 ☐ Yes 2 🛣 No		
	with th	Director	10e. Street and Number		TE DD			10f. Zip Code				. Citizen of What C			
	eath v	Funeral	1448 PLEAS	SANIVIL	LE DK.	lent Ever in U	J.S. 13.	21061 Was Decedent of H		in? (Specify Yes		ITED STA			
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene of other then "natural", or Items 23s or 28s-f ehow event, the Medical Examinal must be notified at	Ď	1 Never Married	_	Armed Ford 1 Yes 2 If Yes, Give Year or Da	es? PANo		Was Decedent of HIf Yes, specify Cub	an, Mexican, Specify:	, Puèrto Rican, e	etc.)	Specify: WH			
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e,	s 1 and of Health item 27 other tr	-	20a. Method of Dispos		ANT DON	20b. I	_	osition (Name of matory or other pla		JULY 6,	-	RNIE, MD			
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	है थिड	iner	Sequentially list condi- if any, leading to immi- cause. Enter Underlyi Cause (Disease or inju-	ing 4	Due to (c	(25 a⊈ ons⇔	nce of):								
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.O. Box	that the death certifica ed by the attending ph detached for use as th	Physician/Med	23b. Was decedent print the past 12 mg	onths?		ome or pregn th 2 □ Feta nt at time of o	al death 3[Ectopic pregnanc	у			23d. Date of de Month	elivery Day Year		
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=	nysicii nis cer direcl	To Be	examiner? 1 Tes 2 No	•	Hospital: 1 In	patient 2] ER/Outpatie	nt 3 DOA Ott	ner			e 6 ∐Other (Spe	ecify)		
0 0	ing Pl		27. Manner of Death 1 Natural	5 Pending		Injury , <i>Day Year)</i>	28b. Time o Injury	Wo			scribe how	injury occurred			
Division of Vital Records,	ttand death ctor: / y the f	ficat	0 - 0410100	investigati	be Ogo Place	of Injury - At h	ome, farm, st	M 1 []Yes 2 □ N		ation (Stree	et and Number or F	Rural Route Number,		
<u>~</u>	s after i Dire	Certification;	4 Homicide	determine	buildin	g, etc. (<i>Speci</i>	fy)	out, idealy, amou			or Town, S				
1	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	edical	29a. Certifier 18 (Check only 25 one)	Certifying F	hysician: To the laminer: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurred at the ti	me, date and opinion, deat	d place, and due th occurred at the	to the caus time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)		
	To the sound of th	Σ	29b. Signature and title Adey	e of certifier	O, he	me	~ ·	29c. Licens	005	9728	J	Date signed (Mon	2006		
	9		30. Name and address	A 1	completed cause		m 23a) (Type, Imore	Print)	m Ma	1-col 0	A. 1.	ilen Burni	mo 21061		
	Sta	ite	31. Date filed (Month,			gistrar's Sign		AA-MAINUT	11160	mon Ce	nee, c	THE ISHIN	-		
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							OFFICE	1 47 Nov							

			1 - State Amend Item	State of Marylan 3 per Dr., G85	d / Departme 7,07/03/0	ent of Health and ball of Death	Mental Hy	rgiene (20750
		wi.	Decedent's Name (First, Middle, Last,				2. Date of De	eath	3. Time of Death
12.	nysicia		Charles	Leon	Wal	KeR	Sone	Day 206	
5535	Medic xamin	_	4a. Facility Name (If not institution, give	street and number)	4b. Ci	ty, Town, or Location of Dea		4c. County of Oe	
200			Joseph Kick	HE HOSP	ice	Baltina			
Fu	neral	===	5. Social Security Number 6. Sec		. Month	der 1 Year If Under 24 Hrs		ay, Year)	irthplace (State or Foreign Country)
Dire	ector	k	3/7-/3-0606 15 Usual Residence of Decedent	3	2 Yrs. Monti		3-1	7-1924 1	Mayband
and	72		10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
Mary	pall	ţō	MI		Baltiv	nore			1 ☐ Yes 2 ☐ No
the	E	lrec	10e Street and Number	4		Zip Code		10g. Citizen of What	Country?
h with	sthe	a D	110 Central	AVC	2	21202		US	, 17
dea	BE THE	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was De	cedent of Hispanic Origin? (Specify Yes or No	14. Race - Ar Black, Wi	nerican Indian,
36 afte	딤		1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		2 No Specify:	,	100	Lack
21215-0036 sd within 72 hours at giene.	al Ex	ed by	3 Widowed 4 Divorced	Year or Dates:	150 Decedent's II	and Convention			
72 12 12 1	olbe	iete	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Decedent's U (Give kind of lif DO NO)	work done during most of wo	orking	16b. Kind of Busines	s/Industry
With Separate	Ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	/2/-	Loader		Dair	1
Ind 21215-0036 be filed within 72 hours after death with the Maryland att Hygiene.	j,	BeC	17. Father's Name (First, Middle, Last)				ame (First, Middle	, Maiden Sumame)	
Jar Juld by Menta	ji Li		UKn			Georg	314		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	Buma		19s. Informant's Name/Relationship (Ty		19b. Mailing Addre	ess (Street and Number or A	al Route Numb	er, City or Town, State	, Zip Code)
and and salth	1	(er wite	110 (entralt	tve. 1	salto. IV	12.21202
altimore,	or of	Ì	20a. Method of Disposition 1i ☐ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	Place of Disposition (A cometery, crematory of	lame of ir other place)	Date	20c. Location - City	or Town, State
timent Page	Jury		4 □ Donation 5 □ Other (Specify)	Me	X WOHER	an Com 10/	21/06	CROWNO	le mi
Balt Permit Depart	ny in		21. Signature of Puneral Service Lights	00,0	22. Name	and Address of Facility	Weller"	mette fer	ilen Chapel
		2	23. Part1. Filer the Sasse, or comple	ications that caused the deat	163	q N. IOREAL	way	BELYE. 1	1. 21213
1	201		shock r heart fail e. List only of	ne cause on each line.	ii. Do not enter the m	ode of dying, such as cardia	ac or res y alony a	iresi,	Approximate Interval Between Onset and Death
Physi /Mo	cian dical		disease or condition resulting in dealh)	uremic					months
Exam	77.40			Due to (or as a conseq	/ 1	15 x 2			
A. 200		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	tic Syndi	rome			
ned uted	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
О, ехес	rial-tr	Exa	resulting in death) Last	Due to (or as a conseq	uence of):				
8760, cate be executed	the burial-transit	dlcal		1					
diffica	as t	Med	IF FEMALE:						
Box eath cert	or use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		pregnancy		23d. Date of d	,
O. E e dead	ned fo	slci	1 Yes 2 No	4□Pregnant at time of d 9□ Unknown	eath 5 Other	(specify)		Month	Day Year
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Division of Vital Records, it or Attending Physician: The law requires the after the centificate has been sinned to be an element of the page of the p	irector, page 2 s	o Be	25. Was case referred to medical examiner?	lospital: 1 Inpatient 2	ER/Outpatient 3	0.1	ath Check only		. h
Phys of	aral d	$\vdash \downarrow$	27. Manner of Death	28a. Date of Injury	28b. Time ol	28c. Injury at Work?		dence 6 MOther (Sp	ecity) hospice
ith.	un e	탏	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
Oivisio or Attendi after death.	by th	HC	3 Suicide 6 Could not be determined	28e. Ptace of Injury · At he building, etc. (Specification)	ome, farm, street, fact	ory, office		Street and Number or I	Rural Route Number,
Div tal or A	ed in	Certification:	4 C Homodo	building, etc. (Specif)	Y)		City or To	wii, Statej	
lospi hour	le fill	edical	29a. Certifier (Check only 2D Medical Exami	sicien: To the best of my kno ner: On the basis ol examina	wledge, death occurre	ed at the time, date and plac	e, and due to the	cause(s) and manner	as stated.
Division To the Hospital or Attending within 24 hours after death To the Funanti Director Atten	completely filled in by the funeral director, page	Med		and manner stated.			a. rod at the tille,		
V Vit	00	<	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mor	
			CROND			y 27110		June 16,	2006
1/	h)		30. Name and address of person who co	impleted cause of death (Item	23a) (Type, Print)	DZ4170 intan St B	2 11.	117 - 1	20-1
1 march 18	Sta	0		82. Registrar's signa	078 1V C	ulaw It 1	DaltaMin	L MU 21	201
R	oia eaistr		31. Date filed (Month, Day, Year)	Desture 15	RECENTER				

State of Maryland / Department of Health and Mental Hygiene 2 1 15 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month 5,25 AM **Physician** AMES WELCH 30,2006 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Mariner Health of North Arundel Glen Burnie If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Months 1 X M 2 □ F 409-66-2866 66 Tennessee Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h Count 10a State 28a-f show 1 TYes 2 No Pasadena AACo. Md. Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number , or itams 23a or 21122 USA 114 Chelsea Grove Ct. death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No 1958
If Yes, Give filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Susiness/Industry 15. Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) Military Contractor Draftsman 12 other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked oth any lightly or other traumatic event once. Welch Roberts Cynthia 01iver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 114 Chelsea Grove Ct. Pasadena, Md. 21122 Barbara Welch (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Loudon Co. Mem. Garden 7/5/06 Lenoir Tennessee 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign sure of Funeral State Logn 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chiling Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complica shock, or heart failure. List only one ions that ause or Immediate Cause (Final disease or condition resulting in death) NEARCTION MYOCARDIAL Few minutes **Physician** /Medical Examiner OPONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMONIA 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No DEPRESSION 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an **≱**S No 2□ No 1 ☐ Yes Division of Vital 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide within 24 hours after To the Funeral Dire 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 025873 07/02/2006 Physician CRAIN HOLY, STE-610 GLEN BURLIE mpleted cause of death (Item 23a) (Type, Print) ELW AL M.D. (6005. 30. Name and address of person who completed cause of death (Iter RITA CHANDELWAL M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUL 0 3 2006 Registrar

		1	For State State Registrar	ate of Maryland / [Department of H Certificate of L		ental Hygie	2000	20752	
	Physicia	an	1. Decedent's Name (First, Middle, Last)		11/- 1-			Day Year	3. Time of Death	
	/Medic	al	1 AYMONA 4a. Fagility Name (If not institution, give street	and number)	4b. City. Town, or	Location of Death	JUNE =	4c. County of Deatl	11.25 #	
	Examin	er 	The Johns Hopkins	1105/11/01	Balti	none		N/	Ä	
	Funeral Director		5. Social Security Number 6. Sex. 12/13-64-1979	7. Age (In yrs. last bir	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye March 29,	9. Birth Co. 1953 Ge	nplace (State or Foreign untry) Prinany	
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	m or Location				10d. Inside City Limits	
	Mary B-f sh	to	Md. Anne Aru	ındel	Pasade	na			1 Yes 2 No	
	vith the	Funeral Director	10e. Street and Number		10f. Zip Code 2112	2	10g.	Citizen of What Co	untry?	
	eath v	erai	9 Penny Lane	as Decedent Ever in U.S.	13. Was Decedent of Hi		cify Yes or No-	USA 14. Race · Ame	rican Indian,	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event, Ite M. died Excuited matter natified at once.	þ	1 Never Married 2 Married 1	med Forces? ☐ Yes 2 ☐ Yoo Yes, Give ear or Dates:	.,	n, Mexican, Puerto I Specify:	Rican, etc.)	Black, White	hite	
21215-0036	72 ho 'natur	Completed	15. Decedent's Education (Specify only highest grade con		Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	ation during most of working	ng 16t	. Kind of Business/	industry	
121	within ene. than "	idmo	Elementary/Secondary (0-12)	ollege (1-4or 5+)	wner Service			haust Cle	aning Co.	
1d 2	oe filed within al Hygiene. I other than "went, I're Ma	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Mai	den Surname)		
ylar	Mental Mental arked c	To B	William	B. Weave		Anna	Ε.		bel	
Maryland	d 2 shoul th and Mi 7 is marl traumati	6.5	19a. Informant's Name/Relationship (Type, F		o. Mailing Address <i>(Street a</i> 06 Piedmont (lip Code)	
	s 1 and f Health item 27 other tr		<u>Jacquelyn L. Smith (</u> 20a. Method of Disposition	20b. Place o	of Disposition (Name of ary, crematory or other place			Location - City or	Town, State	
шo	Page nent o ant: If ary or	li	1 ☐ Burial 2 🂢 Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)		Crematory In	10. 7/3/0		ltimore,		
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or of		21. Signature of Funeral Service Literacee	(1)	22. Name and Addres				e PA	
			23a. Part1. Enter the disease, or complicato shock, or heart failure. List only one ca	ns that caused the death. Do	not enter the mode of dyin	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death	
¥	Physician		Immediate Cause (Final disease or condition resulting in death)	ALdioVAScul	IL COLLAPSE	not hy	extension	7	3 8245	
	/Medical Examiner	П	6	Due to (or as a consequence	of):	· //			3 Jaur	
	7.1. =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence		2			J. Caryl	
	and transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence		EMIA			months	
8760,	e be executed sician and burial-transit	caiE	d	23 15 (67 25 2 551155 4551155	J.,.					
9	rtificate b ng physi as the b	Pa	IF FEMALE:							
O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	/sician/	Physician/M	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal death □ Pregnant at time of death □ Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deli Month	very Day Year
rds, P.O	The law requires that the te has been signed by the age 2 should be detache	by	Part II. Other significant conditions contribu	ting to death but not resulting	in the underlying cause give	en in Part I.	23e. Did tobac		the cause of death?	
Vital Records,	The law re- ate has bee page 2 sho	Completed					24a. Was an autopsy performed 1 Yes 2	prior to death?	topsy findings available completion of cause of	
/ita	Physician: T this certificate ral director, pa	Be	25. Was case referred to medical examiner?	tal	Oth	26. Place of Death				
of		. To	1 Yes 2 No	Ba. Date of Injury 28b.	utpatient 3 DOA Time of 28c. Injury		ne 5 Residenc 28d. Describe how	e 6 ⊡Other (Specinjury occurred	cify)	
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	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	(Check only 2 Medical Examiner:	n: To the best of my knowledg On the basis of examination a and manner stated.						
	To the within To the comp	Me	29b. Signature and title of certifier	Ballas	29c. Licens	e number 206299	1 1-	Date signed (Monti	-	
	5		30. Name and address of person who comple Marc S: Ba	1/as 600)	4. WOLFES	St. Balt		Azyland		
:	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUL 0 3 2006	. Registrar's Signature	Goade			/		

Dean Allen Waterman

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 20753

		I- For State Registrar		Certifica	ate of D	eath			Reg	g. No.	Comme Control	JU	-010
Physici		Decedent's Name (First, Midd											e of Death
Medical Exami	ner	DCAN . A 4a. Facility Name (if not institution	. WATERN	IAN				Jui	ne 21, 2	006			02 hrs
g.Z.f.						City, Town, or L	ocation of De	eath		1	ounty of De	ath	
V*	Щ.	Route 152 Northbour				орра					ford		
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Director	- 1	002-70-6012	1 M 2 F	35	Yrs.	VIOLITIS	Tiodis 1	J	une l'	9,19	71	Country)	NH.
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ath with the items 23a	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.		ecedent of Hisp				14.	Race - Am		ian, 8lack,
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ours	호[15. Decedent's Education (Spe	ecify only highest grade com			Jsual Occupation of working life. I			one	16b. Kind	of Busines	s/Industry	
5-0036 led within 72 hou Hygiene other than "nat	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	i+)				(cuica)	·				
oo3 vithir ene er th	Ē	lath	NA		INE	chani			i		TO.		
5-C		17. Father's Name (First, Middle				18	8.Mother's Na			aiden Sur	name)		
2121 Id be fill Mental H narked event,	Be		ERMAN	Lin				Know					
MD 21215-0036 1 2 should be filed within 72 hours after death with the Maryland thand Mental Hygrene n 27 is marked other than "natural", or items 23a or 28a-f shound it event, the Medical Examiner must be notified at once	P	19a. Informant's Name/Relation				Idress (Street							
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Balti Sermit. Separtr Import njury		21. Signature of Funeral Service			22 Nam	e and Address of STEIL	of Facility	neka	1 140	me,	PA		
	1		Stella		75	27 hay	for R	O. BA	Ho. 1	40 . s	21239		
Physician		23a Part I. Enter the disease, of failure. List only one cause		the death, Do no	ot enter the n	node of dying, s	uch as cardia	ac or respi	ratory arres	st, shock,	or heart		oximate Interval veen Onset and
/Medical Examiner		Immediate Cause (Final disease	e a. Multiple Injuries										Death
zzamne.		or condition resulting in death)	Due to (or as a conse	quence of).									
	ایا	Sequentially list conditions,	b	and of						_		_	
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8760, tificate be ng physic as the bur	Š	IF FEMALE:	23c. If yes, outcom							23d. D	ate of delive	ery	
∞ = ≅ ≈		23b. Was decedent pregnant in past 12 months?	I Live billi		Fetal		Ectopic pre	gnancy		Mo	onth	Day	Year
Box 68 e death cert the attendir ed for use a	Sic	1 Yes 2 No 9 Ur	nknown 9 Unknown	time of death	Other	(Specify)				1			2
D. B t the d by the	Physicia	Part II. Other significant cond		but not resulting	a in the unde	erlying cause giv	ven in Part I.	2	3e. Did tob	acco use	contribute	to the cau	se of death?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#10a-c, e-f, perInf. C857, 7/19/06 TT State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 Pear JUNE **Physician** 29 2:55 A M WALPERT M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE TOWSON HOSPICE OF BALTIMORE GILCHRIST CTR. Months Days Hours Min. 01 02 1935 Birthplece (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**∑**M 2□F 213-32-0954 Director Usual Residence of Decedent with the Marylend 10a. State 10c. City, Town or Location Naples 10d. Inside City Limits 10b. County Collier "natural", or iteme 23a or 28a-1 ehow other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director BALTIMORE BALTIMORE MD 10f. Zip Code 34119 10g. Citizen of What Country? 610 Laguna Royale Boulevard # 1003 4001 OLD COURT ROAD #320 21208 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🕅 Married WHITE Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTING & LAW CPA & ATTORNEY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I BARRIS WALPERT ROSE WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2: Department of Health ar Importent: If Item 27 is any injury or other trau 4001 OLD COURT ROAD #320 - BALTIMORE, MD 21208 FERNE WALPERT / WIFE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHIZUK ÁMUNO CONG. 06/30/2006 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee May Le 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CArcinoma **Physician** lear /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: After this certification, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ို 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending after death.

Director: Aft
J in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) June 29,2006 125205 no $\mathcal{I}_{\mathcal{O}}$ who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto. Md 21204 6701 SMC 32. Registrar's Signature 31. Date filed (Month, Day, Year) State and I 0 3 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) р м **Physician** 15, 2006 6:16 June De Jesus Arqueta /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring
Under 1 Year | If Under 24 Hrs. Montgomery Birthplace (State or Foreign Country) Holy Cross Hospital
5. Social Security Number 6. Sex If Under 1 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days **Funeral** Min. 1(\$ M 2 □ F 0 Yrs 5 None 0 0 1 June 15, 2006 Maryland Director Usual Residence of Decedent 10d, Inside City Limits with the Maryland 10c. City. Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene, Important: if item 27 is marked other then "natural; or iteme 23s or 28s-f show eny linity og other traumatic event, the Medical Examinat must be notified at once. 1 Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 20903 325 South Hampton Drive Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1⊠Yes 2□No Specify: Salvadoran Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A Never Worked 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Keire Jaheli Jose De Jesus Arqueta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 325 South Hampton Drive, Silver Spring, MD 20903 Jose De Jesus Argueta/ Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State June 19, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Silver Spring, Maryland Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** anencephal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to in modale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of] Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physiclan/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 2 No 1 ☐ Yes certificate Physician: funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Hospital or Attend 24 hours after death Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral I completely filled Receitifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier 00467 Wruan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 M.D. Sharon C. Kiernan, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2006 Registrar

		1	For State Registrar	State of M	aryland / De	partment Certificate			ind M		ene () () 6	20756
	Physicia	in	Decedent's Name (First, Middle, ZAHUR	ALAM						2. Date of Death Month June 15	Day	Year	3. Time of Death 7:15 A M
	/Medic Examin		4a. Facility Name (If not institution, Washington Adve			1		Location o			4c. County	of Death	rv
	Funeral Director				ge (In yrs. last birtho	fay) If Under		If Under 2 Hours		8. Date of Birth (Month, Day, Jan. 1,	1		place (State or Foreign
	aryland show	-	Usual Residence of Decedent 10a. State 10b. County Maryland Montgon	nerv	10c. City, Town of Silver							1	Od. Inside City Limits 1 ☐ Yes 2 🕅 No
	vith the Ma t or 28a-f be notifie	Directo	10e. Street and Number 13738 Notley Rd			10f. Zip	Code			10	g. Citizen of V	hat Cour	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or them 23a or 28a-f show eny injury or other traumatic event, the Macalcal Executive must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces			ent of Hi	ispanic Orig n, Mexican Specify:	jin? (Spe , Puerto I	cify Yes or No- Rican, etc.)	14. Race	k, White,	can Indian, etc. ite
Maryland 21215-0036	within 72 hou piene. r then "nature Ine Madical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or	5+)	ecedent's Usua Give kind of woi fe. DO NOT us tistici	k done d e retired	uring most	of workii	ng 1	6b. Kind of Bu		
land ;	uld be filed dental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, L. Mohammad	ist) [brahim				Jir	nat	(First, Middle, M Bibi	aiden Sumam	ө)	
Mary	alth and h		19a. Informant's Name/Relationshi Zohair Alam / So		1					Route Number, Sandy			
Baltimore,	Pages 1 and not of Herminy or other		20a. Method of Disposition 1		20b. Place of D cemetery. Ft. Lin	crematory or o	ther plac	6	/15/		oc. Location - rentwo		
Balti	permit. Departm Importa eny Inju		21. Signature of Funeral Service Li	Bryw	wit					Funeral Belts			0705
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	/Medical Examiner		resulting in death)	Due to (or as	s a consequence of) Failure								
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О. Вох	The law requires that the death certificat ale has been signed by the attending phy age 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Fetal death at time of death	3 □Ectopic pr 5 □ Other (sp				40	23d. Dat Mo	e of deliventh	ery Day Year
Δ.	w requires that the death been signed by the atte should be detached for		Part II. Other significant condition	s contributing to death	but not resulting in t	he underlying o	ause giv	en in Part I.					he cause of death?
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Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	Hospital: 1 X Innat	ient 2 ☐ ER/Outp	atient 3□ DC	Oth	05		n (Check only one		er (Speci	6/1
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Divis	To the Hospital or Attendi within 24 hours after death. * To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could n 4 Homicide determin	and 289, Place of Ir	njury - At home, farn tc. <i>(Specify)</i>	n, street, factor	, office			28f. Location (Str City or Town	eet and Numb State)	er or Run	al Route Number,
	te Hospita 24 hours ne Funera	edical (Physician: To the bes xaminer: On the basis and manner s	of examination and/								
	To the vithing comp	¥	29b. Signature and title of certifier			290		e number 58864		1	id. Date signed une 15		* '
	Ψ		30. Name and address of person v	tho completed cause of in, MD 6510			#26	500 R	iver	dale. Md	20737		
	Sta Registi		31. Date filed (Month, Day, Year) JUN 16	2006 Regis	trar's Signature	barke				,			

		4		State of Man		epartmer	nt of H				20757
	7 180		State RegistrerAMEND#1perMD(1. Decedent's Name (First, Middle, Last)	ROBERT /	W,MoCo ⁽ K ENT	ADAMS	e or L	Jean	La Bur d'De	Reg. No. ath Day Year	3. Time of Death
	Physicia /Medic		Kober		dan	75-			Month 0	0 11 200	
	Examin		ta. Facility Name (If not institution, give si	treet and number)	tospita	al Bo	Town, or	Location of Deat	rity	4c. County of Dea	Îq
184°	Funeral Director		5. Social Security Number 6. Sex. 120	7. Age (/ M 2 F	In yrs. last birth	nday) If Unde Months	r 1 Year Days	If Under 24 Hrs Hours Min.		y Year	nthplace (State or Foreign ountry) YLAND
- 49 c	and *		Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town	or Location					10d. Inside City Limits
	Maryla a-f aho	tor	MARYLAND BALTIMORE		ELLICOT	I CITY					1 ☐ Yes 2 🙀 No
	with the 3a or 28a if be not	i Director	10e. Street and Number 778 HOLLOW ROAD		Miller Miller (Bright Green) of the Miller (Bright Green) (Bright	10f. Zi	p Code 21043			10g. Citizen of What C USA	ountry?
980	within 72 hours atter death with the Maryland ene. than "naturat", or itame 23e or 28e-f ahow I.a Medical Examinat maat ke notifikat at	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 ★Yes 2 No If Yes, Give Year or Dates: 58		13. Was Dece If Yes, spe		spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		
21215-0036	be filed within 72 ho ital Hygiene. id other than "natur event, it e Madical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)		life. DO NOT i	ork done a use retired,	furing most of wo)	rking	16b. Kind of Business	,
	be filed ital Hygi of other event, I	Be	17. Father's Name (First, Middle, Last)	UKN	BU	ILDING CO	INTRAC.			Maiden Sumame)	LON
Maryland	s 1 and 2 should f Health and Men Item 27 le marka other traumatic	ဥ	19a. Informant's Name/Relationship (Type KIRSTEN S. SMITH - DAU			-		and Number or R		er, City or Town, State,	Zip Code)
Baltimore,	Pages 1 and 3 nent of Health int: If Item 27		20a. Method of Disposition 1 Burial 2 Acremation 3 Re 4 Donation 5 Other (Specify)		20b. Place of cemetery	the second second second second	me of other place	θ)	Date	20c. Location - City o	
Baltir	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service License	Elbert	70112 112	22. Name a	nd Addres	s of Facility HI	NES-RINALD	FUNERAL HON	Æ
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56.	/Medical Examiner		resulting in death)	Due to (er as a c	consequence of	f):	ILV	CHIVIV			
	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c							
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<u>α</u>	w requires that been signed b should be deta	þ	Part II. Other significent conditions con	tnbuting to death but	not resulting in	the underlying	cause give	en in Part I.		obacco use contribut <i>e</i> Yes 2□No 3□F	to the cause of death? Probably 4. Unknown
I Records,		Completed					_			an 24b. Were a prior to death? 2 Wo 1 Ye	
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o	ng Phy tter this uneral d	ilon: To	27. Manner of Death 1 Natural 5 Pending	1 Inpatient 28a. Date of fnjury (Month, Day)			28c. Injun World			dence 6 Other (Sp how injury occurred	ecify)
Division	l or Attending after death. Director; After I in by the fune	ertificat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, far (Specify)				28f. Location (: City or To	Street and Number or F wn, State)	Rural Route Number,
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	To the within 2	Me	29b. Signature and title of certifier	in L	no	2	9c. Licenson	1264		29d. Date signed (Mor	nth, Day, Year)
	J		30. Name and address of person who co	impleted cause of dea	ith (Item 23a) (Type, Print)	T. 1	Balton	or MD	21201	
	St. Regist	ate rar	31. Date filed (Month, Day, Year)	32 Registrar	s Signature	fraile	9		7		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 20758

Physician
/Medical
Examiner

		•	= State Registrar		(Certi	ificate of	Death			Reg. No.	0 0 0	0 ,
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day							Year	3. Time of Death
	Physicia		Eleanor	Sheffer		Bis	ser			June	25, 2	2006	1222 a ^M
Ser.	/Medic Examin		4a. Facility Name (If not institution, give s				4b. City, Town, o	r Location	of Death		4c. Cou	inty of Death	
			Northampton Mano	r Nursing	Center		Fred	erick			Fr	rederi	ck
	Funeral		Social Security Number 6. Sex	7. Age ('In yrs. last birth	,,	ff Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birth	place (State or Foreign intry)
Ш	Director		214-34-1190	M 2KGF	93 Y	rs.				Jun 23	, 1913		yland
	D .		Usual Residence of Decedent 10a. State 10b. County	1,	Oc. City, Town	or Loca	tion						10d. Inside City Limits
	ehov d	_	Maryland Freder:		ou. ony, roun		ederick						1 XYes 2 □ No
	Ba-f	Director	40- 01				10f. Zip Code				10g. Citizen	of What Cou	unter?
	with t	ä	10e. Street and Number 200 East 16th Str	cont				L701				S.A.	may:
	se 23	Funeral		2. Was Decedent Ev	er in U.S.	13 W	L		igin? (Spe	cify Yes or No		Race - Ameri	ican Indian.
	Item	'n	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛱 No			as Decedent of F res, specify Cub		n, Puerto F	Rican, etc.)		Black, White,	
336	urs af	þ	3 Nidowed 4 Divorced	ff Yes, Give Year or Dates:		1 [JYes 2█ No	Specify:			Spe	ecify: Wi	hite
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pu	be filed ital Hygid of other event, I	Be	17. Father's Name (First, Middle, Last)		۸1 ₀ - ٦	1.		18. Mothe		(First, Middle	, Maiden Sun	name)	5 7
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Maryland	2 she and le m		19a. Informant's Name/Relationship (Ty)				Address (Street						
	and 2 ealth m 27 her tru		Mrs. Eleanor Lee	Off, Daug	20b. Place of		2 Lander	: Koac		fierson			
ore	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery	r, crema	itory`or other pla	· 1				on - City or T	
Ë	ment tant: jury		4 ☐ Donation 5 ☐ Other (Specify)		Kerorm		Cemetery			2006			Maryland
Baltimore,	permit. Pages, 1 and. Depertment of Health Important: if Item 27 eny injury or other tr		21. Signature of Funeral Service License			22.	Name and Addre Keeney	Bas:	ford	P.A. F	uneral	Home	
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			shock, or heart failure. List only or	e cause on each fine	. D	1		L.		i rospilatory a			Interval Between Onset and Death
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		er	Sequentially list conditions,	Due to (or as a	consequence o	0:							
./	red nslt	듣	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
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	tifical og phy as th	Medical											
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	deat	SC	in the past 12 months? 1 ☐ Yes 2 🗷 No	4☐Pregnant at ti			Other (specify) _	·				Month	Day Year
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Sign	Attending r death. ector: Atter	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injur	v - At home, far	m stree				28f. Location (Street and N	umber or Ru	ral Route Number,
Division of Vital Records,	or A efter Direction by	erti	4 Homicide determined	building, etc.	(Specify)	111, 31101	st, ractory, ornos				wn, State)		
_	To the Hospitel or Attending Physicien: The lav within 24 hours effer death. To the Funerel Director: Affer this certificate has completely filled in by the funeral director, page 2	edical CertIfication:	29a. Certifier 1 Certifying Phy	sician: To the best of	my knowledge	. death	occurred at the ti	ime, date a	nd place.	and due to the	cause(s) and	manner as	stated.
	24 h 24 h Fur etely	dici		ner: On the basis of e and manner state	examination and								
	ompl	₹ S	29b. Signature and title of certifier				29c. Licen	se number			29d. Date si	aned (Month	, Day, Year)
	F > F 0		2 IV, Pour	el			D	22	03.	7	6/	26/	2006
	0		30. Name and address of person who co	empfeted cause of de	ath (ftem 23a) (Туре, Р	rint)						. `
	3		L Kinland	PMD	61	0	NINTH	AU	15	131	unin	ick,	MD
	St	ate	31. Date filed (Month, Day, Year)		's Signature		-						
	Regist	rar	JUL 3 - 2006	Mila	18 1	284	30						
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		-	For State Registra Amend #5 Pe	State of Ma	ıryland	d / Depa	artme		ealth ar		ental Hy		_	2075	59
	Physicia	an	1. Decedent's Name (First, Middle, La Alice Mae B	ast)	//1//	'Ub JH				2	2. Date of Dea Month	Day	ZOYear	3. Time of Death	h M
	/Medic Examin	er	4a. Facility Name (If not institution, given the second se	ive street and number)	1905 (In yrs. la	ast birthday)	CUI	NBL-R er 1 Year	Location of	4 Hrs. p	3. Date of Birt	<i>F</i>	County of Dea	MY	eign
	Funeral Director		216-32-9238 Usual Residence of Decedent	1 M 2 F 7. Age	83	Yrs.	Months	Days	Hours	Min. 1	1/24/1	922	Wes	t Virginia	1
Maryland	-f show	tor	MD 10a. State 10b. County Allegan	ıy	-	, Town or Lo Town	cation							10d. Inside City Lin 1 ☐ Yes 2XX	
h with the	3a or 28	Funeral Director	10e. Street and Number 24607 Old Town	Rd.				ip Code 2 1 555				10g. Citiz	en of What Co	ountry?	
: I Z I 3-UU30 within 72 hours after death with the Maryland	ital Hygiene. nd other then "naturel", or iteme 23a or 28a-f ehow event, ine Madical Examirat must be notified at	þ	11. Marital Status 1 Never Married 2 Married **XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	Ever in U.S Io	i	Was Dec If Yes, sp		spanic Origi n, Mexican, Specify:	in? (Speci Puerto Ri	ify Yes or No ican, etc.)		4. Race - Am Black, Whi Specify: W.		
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	d other	Be	1 17. Father's Name (First, Middle, Las James Corbin			Labo	r				First, Middle,		cken F	actory	
Maryia 42 should	of Health and Men If Item 27 is marks or other traumatic	2	19a. Informant's Name/Relationship Rhonda Wolfe/Gra	(Type, Print)		19b. Mailir	•				Route Number	ar, City or	Town, State,	Zip Code)	
more,	intment of Health intant: if Item 27 njury or other tr		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Spec	☐Removal from State		ace of Dispo emetery, crer	sition (N matory or	ame of other place	9)	Da			ney, W		
Daltimor	Departmen Important: eny injury once.		21. Signature of Funeral Service Lice	- AN - A - /		22	2. Name	and Addres	s of Facility		eral Ho		•	Main ₂ St WV 26757	
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e di contra di c	24 hours	Medical C	29a. Certifier (Check only one) 1 Certifying F	Physician: To the best of aminer: On the basis of and manner sta	examinat	wledge, deat tion and/or in	th occurre	d at the time	ne, date and pinion, death	d place, ar	nd due to the d at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)	,
)	within 2 To the	Ň	29b. Signature and title of centrer	2, for				9c. License		υ			e signed (Mon		
	Sta		30. Name and address of person who are also and address of person who are also and address of person who are also are also are also and address of person who are als	o completed cause of de	25	Ken	Print)	venc	ie. (Cur	berla	210	mo	2006	
¥	Regist	rar	201 9 - 70	NO AND IN	1 Fin	Sign	Willand								

			1 - For State Registrar	State of Maryla	•	ertificate of			giene Reg. No.	2006	20760
			1. Decedent's Name (First, Middle, Las	t)				2. Date of De	ath Day	Year	3. Time of Death
	Physici: /Medic		Rose Marie Ba	rnett				JUNE	27	2006	3: 25amm
	Examin		4a. Facility Name (If not institution give	0 1 1 -		4b. City, Town, o	r Location of D	eath	4c. 0	County of Death	\
			LORIEN (0	KIVERSIDE		If Under 1 Year	If Under 2	2	17	NKT OK)
	Funeral		5. Social Security Number 6. Social Security Number 6. Social Security Number 1	9x 7. Age (In yrs ☐ M 2 ☐ XF 40	. <i>Iast birtnd</i> ay Yrs.	Months Days		Hrs. 8. Date of Bir (Month, Da NOV • 1	y, Year)	Cou	place (State or Foreign ntry) cyland
	Director		Usual Residence of Decedent	40				FIOV. 1	1 20	J Ma.	Lyland
o e l'e	ylain how		10a. State 10b. County	10c. C	ity, Town or L	ocation					10d. Inside City Limits
Mo	e-f-e	ctor	MD Harford		Belcan	ib					1 ☐ Yes 2 🛣 No
d ZIZI 5-0030	De liled within 7.2 mous arier beart with the waryar and thy figher. A collect than "netural; or iteme 23a or 28e-f show event, the Moulcal Examiner must be notified at	Director	10e. Street and Number 4534 Perkins Ct.			10f. Zip Code 210	17		10g. Citiz	en of What Cou	ntry?
4	e 23e	Funeral		12. Was Decedent Ever in I	15 12			2 (Specify Ves or No		4. Race - Ameri	can Indian
- 4	item	un.	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Amed Forces?	0.3.	If Yes, specify Cub	an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	Ì	Black, White,	etc.
3-003c		þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔯 No	Specify:		,	Specify: Whi	te
	netur Icel	Completed	15. Decedent's Ed (Specify only highest gra	lucation	16a. Dec	edent's Usual Occup	ation during most of	working	16b. Kin	d of Business/Ir	ndustry
7	9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		e kind of work done DO NOT use retire	d)	•	D1	1	
7	e illed within al Hygiene. I other than vent, Ire Me	Co	12 17. Father's Name (First, Middle, Last)	0	ВС	okkeeper	19 Mothor's	Name (First, Middle		kkeepin	3
	e da la	Be	Francis L. Hessl					A. Benczk			
	z should be and Mental ie marked (eumatic ev	5	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street		r Rural Route Numb			p Code)
	nit. Pages I and 2 should artment of Health and Mer ortent: if item 27 ie marke injury or other treumatic		Richard L. Barne	**	453	4 Perkins	Ct.	Belcamp	, Ma	ryland	21017
e .	other tr		20a. Method of Disposition		Place of Disp	position (Name of ematory or other pla	ce)	Date	20c. Loc	ation - City or T	own, State
ב ב	t. Pages tment of h tent: if it		1X Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify			Cemetery		1/06	Havr	e de Gra	ace, MD
Baitimore,	permit. Page Department of Importent: if any injury or once.	1	21. Signature of Funeral Service Licer	isee	ah a	22. Name and Addre	ss of Facility	Funeral F	Ioma	DΔ	
D .	20599		23a. Part1. Enter the disease, or com	up Chique	Hel			Funeral Hyland 210		399	Approximate
•	nysician /Medical Examiner	ner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a	High of):	rion					Interval Between Onset and Death
98/60,	icate be executed physicien and sthe burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	equence of):						
O. Box 6	the death certif by the attending ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnanc ☐ Other (specify) _	у		2	3d. Date of deliv	ery Day Year
ds, P	w requires that been signed b should be det	by	Part II. Other significant conditions of	Nismar		underlying cause gr	ven in Part I.		tobacco us Yes 2 🖺		the cause of death? bably 4 □Unknown
Records,	Physicien: The law rec rthis certificate has bee ral director, page 2 shoi	Completed	horpexi	erreplation	X's			24a. Was auto perfe			opsy findings available ompletion of cause of
Vital	ilen: artifica ctor, J	Be	25. Was case referred to medical examiner?					Death (Check only			
<u> </u>	hysic his ce Il dire	2	1 ☐ Yes 2 DNo	Hospital: 1 ☐ Inpatient 2				ng Home 5 Res			fy)
ם ב	ing P	on:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo	rk?	28d. Describe	how injury	occurred	
0 0	tendi death. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not b		homo form		Yes 2 ☐ No		Street and	Number or Ru	al Route Number,
Division of	of or Attends after death Director: A d in by the f	Certification;	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)	street, ractory, onice		City or To		Traniber of Flai	ar House Humber,
	To the Hospitel or Attending Physicien: within 24 hours after death of To the Funerel Director. After this certific completely filled in by the funeral director,	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	nysician: To the best of my kinner: On the basis of examinand manner stated.	nowledge, de nation and/or	ath occurred at the ti investigation, in my	me, date and p opinion, death o	place, and due to the occurred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within To the comple	M	29b. Signature and title of certifier	1.		29c. Licen				signed (Month	
			KACU,	Melly un)	nô	1797	7	61	27/06	
	3		30. Name and address of person who	completed cause of death (It	em 23a) (Typ	e, Print)		Bel	J	1 0-	200000
	~		31. Date filled (Month, Day, Year)	32 Registrar's Sig	O / U	vachas	110	19.00	MV	un	21014
	St: Regist	ate rar	31. Date filed (Month, Day, Year)		As A	wants 8					

DHMH 17 Rev 1/2001

BARNETT

	1	For State Registrar		aryland / De		f Health a	and Mental Hy		20761
Physicia: /Medica	n	1. Decedent's Name (First, Middle, Goldie May Ba					2. Date of De Month June	Day Year 26,2006	3. Time of Death 3:00 P. M
Examine	r	4a. Facility Name (If not institution, 16438 Raven Ro	ck Rd.		Casc			4c. County of Death Washingt	on
Funeral Director		5. Social Security Number 219-82-3338 Usual Residence of Decedent	3. Sex 1 ☐ M 2 🔀 F	9 (In yrs. last birthda 89 Yrs.	Months Da		Min. 8. Date of Bir (Month, Date of Sept. 1	th ay, Year) 9. Birth Cou ,1916 Mar	place (State or Foreign intry) YLand
faryland	. [10a. State 10b. County	ington	10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2 No
with the A 3a or 28a-	II Direct	10e. Street and Number	Rock Rd.		10f. Zip Cod	217]	19	10g. Citizen of What Co. U.S.	
ore, Maryland 21215-0036 stand 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural, or iteme 23a or 28a-1 show other traumatic event, the Madical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces d 1 Yes 22 If Yes, Give Year or Dates:	Ever in U.S. 13	3. Was Decedent of If Yes, specify C		gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - Amer Black, White Specify:	
215-0 within 72 ho ne. nan "natur Medical	npieted	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or	(Gi	cedent's Usual Oc ve kind of work do b. DO NOT use re	ne during mos tired)	t of working	16b. Kind of Business/li	
Maryland 21215-0035 dd 2 should be filed within 72 hours af lith and Mental Hygiene. 27 Ie marked other than "natural", or reaumatic event, ina Madical Evann reaumatic event.	ge	17. Father's Name (First, Middle, L Henry R. Sn			Homem		or's Name <i>(First, Middle</i> Janetta M.	, Maiden Sumame)	ie
Marylanc	0	19a. Informant's Name/Relationshi Floyd E. Baker (p (Type, Print)				er or Rural Route Numb	er, City or Town, State, Zi a. 17225	ip Code)
Baltimore, sernit. Pages 1 ar Department of Hea Important: If item amy injury or other DICE.		20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other (Sp.	3 □Removal from State	cemetery, c	position (Name of rematory or other p Cemeter	place)	June 29,	20c. Location - City or T	
Baltimo permit. Pages Department of Important: If i		21. Signature of Funeral Service L	censee	MD1414 3	22. Name and Ad		7 77	525 Bradbury ithsburg,Md.	
Fnysician /Medical Examiner		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a	a consequence of):		dying, such as		rrest,	Approximate Interval Between Onset and Death
ate be nysicie	Ical Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of): a consequence of):					_
at the death certificat by the attending phy tached for use as th	Physician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ∐Live birth 4 ∐Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify,			23d. Date of delin Month	very Day Year
S, es the igner	2	Part II. Other significant condition	s contributing to death t	out not resulting in the	underlying cause	given in Part I.		obacco use contribute to Yes 2 □ No 3 □ Pro	the cause of death?
Vital Records, P.O sician: The law requires that the certificate has been signed by the irector, page 2 should be detached.	Completed						24a. Was auto perfo 1 □ Yes	ormed? prior to co	opsy findings available ompletion of cause of
of Vital F Physician: Th this certificate al director, pag		25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpati	ent 2 ☐ ER/Outpat	ient 3□ DOA	0.11	of Death Check only or	one) dence 6 □Other (Spec	fy)
DIVISION OF I or Attending Phy after death. Director: After this in by the funeral d		27. Manne eath 1 atural 5 Pending 2 Accident investigs	tion	rry 28b. Time y Year) Injun		njury at Work? ☐ Yes 2 ☐ I		how injury occurred	
DIVISION Itel or Attending a ster death. Itel or Attending a ster death. Itel birector: A led in by the fu	Certification;	3 Suicide 6 Could no determin	building, el	ury - At home, farm, cc. (Specify)			City or To		
Division of Vita Votre Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best xaminer: On the basis of and manner s	∦éxam ınation and/or	investigation, in m	e time, date an ny opinion, dea ense number	d place, and due to the th occurred at the time,	cause(s) and manner as date and place, and due to 29d. Date signed (Month,	o the cause(s)
V = 3 ± 8		30. Name and address of person w	to completed cause of	death (Item 23a) (Tun	1	230	23	June 2	L 200 b
H		3. Date filed (Month, Day, Year)	6 Kings	rar's Signature	> IIII O	me	hud Ca	more Re	(
State Registra	r		2006	a de	A 15 0			Hegerst	fur hus
DHMH 17 Rev 1/200	11			ORIG	INAL			5	1545

06-04174

James Joseph Butler

Please Type or Print in Black Indelible Ink

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State o	f Maryland	Department of Health and Mental Hygier

ames ooseph b	1	- For State Criticate of Death legistrar Certificate of Death		Reg. No2	006 2076
Physicia	n/	Decedent's Name (First, Middle,Last)	Date of D Month	Day Ye	3. Time of Death
Medical Examir		James Joseph Butler	June 16	4c. County	1300 hrs
	•	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loca 3513 Nicholson Street Hyattsville	ation of Death		George's
Funeral			Under 24Hrs. 8. Date of	Birth (MM/DD/YYY	Y) 9. Birthplace (State or
Director			Hours Min. Sept.	6, 1913	Foreign Pennsylvania Country)
	- h-	Usual Residence of Decedent 10a State 110b. County 10c. City, Town or Location			10d Inside City Limits
w any					1 Yes 2 No
taryland 28a-f show Lat once.	흱	Maryland Prince George's Hyattsville 106. Street and Number 107. Zip Code	<u> </u>	10g. Citizen of V	
Baltimore, MD 21215-0036 Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	3513 Nicholson Street 20782		T.	JSA
with t ns 23a be not	힏	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispania		No- 14. Rad	ce - American Indian, Black, ite, etc.
death or iter must	Funeral	Never Married 2 Married 1X Yes 2 No			
s after rral",	2	3 X Widowed 4 Divorced If Yes, Give Year 1942–45 1 Yes 2 No spiral Top Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (White Business/Industry
2 hour	Je -	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO			·
036 ithin 7 ne. r than	Completed	12 Printer			al Government
5-00 fled wit Hygien I other the Ma		11. Patier & Harris (Fines, Image) East)	Nother's Name (First, Midd Lucy Leopard	e, Maiden Surnam	ne)
ID 21215-0036 should be filed within 7 and Mental Hygiene. 77 is marked other than natic event, the Medical	Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and		Number, City or To	own, State, Zip Code)
1D 2 2 shou 1 and N 27 is n matic	립	John J. Butler/ Son 17213 Blossom		•	MD 20832
ore, ME s I and 2 s of Health a If item 27	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemeter	ry, Date		n - City or Town, State
Pages ent of int: If		1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 Donation 5 Other Specify:	June 20, 2006	Silver	Spring, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite injury or other traumatic event, the Medical Examiner must	İ	21 Signature of Funeral Service Licensee 22 Name and Address of Francis			
		23a Fart I. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such			Spring, MD 2090. Approximate Interval
Physician /Medical		fàilure. List only one cause on each line.		arrost, sriesk, st	Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	SC		
λ,		Sequentially list conditions, b.			
	ie	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause c.			
sit d	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
760, reate be executed physician and the burial - transit		d. UNPENDED AMENDED			
760, icate be e physicia	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d Date	of delivery
5876 ertifica ling ph	-	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy	Month	Day Year
Box 68760, e death certificate be the attending physici ed for use as the buri	hysician	4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
the	Δ.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I 23e. D	id tobacco use cor	ntribute to the cause of death?
, P.(d by		1	Yes 2 No	3 Probably 4 V Unknown
rds requi	Completed	(<u> </u>		utopsy	Were autopsy findings available prior to completion of cause of
eco he lav ate has	E E			erformed? es 2 No	death? 1 Yes 2 No
al Rain: T	BeC	Lo. 11do dado 1 da la la la la la la la la la la la la la	Death (Check only one)		
Division of Vital Records, P.O rate or attending Physician: The law requires that the starter death. The Division of March or and the starter of the starter of the starter of the starter or an order of the starter o	10	1 V Yes 2 No Inpatient 2 ER/Outpatient 3 DOA	,	Residence 6	Other: Scene
n of ding l h. Afte		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at 1 Yes		ibe now injury occi	uned
ivisior or Attend after death Director:	cati	2 Accident Investigation 28e, Place of Injury - At home, farm, street, factory, office build	ling, etc. 28f. Location	on (Street and Nun	nber or Rural Route Number, City
Division of Vital I pital or Attending Physician: ours after death eral Director: After this certifi filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined (Specify)	or Tow	n, State)	
Hos 24 hr Fun tely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date a	and place, and due to the	cause(s) and manr	ner as started.
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated 29b. Signature and title of certifier 29c. License nu			gned (Month, Day, Year)
141	Σ	29b. Signature and title of certifier 29c. License nu O. C.M.E		June 17,	
		30. Name and address of person who completed cause of death (Item 23a)		35.15 17,	
		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore,	, MD 21201		
S	tate	31. Date filed (Month Pay, Year) 9 2006 32. Registrar's Signature			
Regis	trar	JUN 1 9 2006 Banes S. April			

State of Maryland / Department of Health and Mental Hygiene 20763 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2006 2:00p M June 10, Melton James Black, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges 6134 Westland Dr. Hyattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**፭**M 2□F Yrs. Feb. 1, 1942 Panola Co Texas 462-56-1128 64 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
ant: If item 27 is marked other then "naturet", or items 23s or 28s-1 ehow ury or other traumatic event, it a Medical Examinat must be motified at 1X Yes 2 No Director MD Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20782 Funeral 6134 Westland Dr 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 1 No 1965 If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Coilege (1-4or 5+) Tech Engineer Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Melton James Black Sr Eva Lee Starling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maeola V Black /wife 6134 Westland Dr Hyattsville MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 23, 2006

Cheltenham Maryland permit. Pages
Department of H
Important: If ite
sny injury or of 1 TxBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility
2017 Pennsylvania Av. S.E. Washington, D.C. 20020

Approximate 21. Signature of Funeral Service Licensee 23a. Parti (Enter the disease or complicated sthat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMON ARY **Physician** HYPERDENSIGI resulting in death) /Medical Due to (or as a consequence of) Examiner RECURENT Emso monne Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Completed by Physician/Medical Examiner ng physicien and as the burial-transit The law requires that the death certificate be executed - ENS ULIN that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. signed by the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 Probably 45€Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes page 2 autopsy performed? 2□ No certificate 1 TYes 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home STResidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 1 Ves 2 No 3□ DOA this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 🔽 Natural 5 Pending investigation after death. M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 24 hours after of Funeral Direc 4 | Homicide (a) Certifying Physinian: To the best of my knowledge, death occurred at the time, date and clans, and due to the rauss(s) and nanner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 298 Certifier (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M.D. 1 30. Name and ad ss of person who was ted cause of death (Item 23a) (Type, Print) 0/8 31. Date filed (Month, Day, Year) State JUN 1 9 2006 Registrar

			For State Registrar	St	ate c	of Mary		partmei ertifica				lental Hy	giene Reg. No.	211115	20764
			1. Decedent's Name (First, Middle	, Last)								2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		Vermell	Р.		Brow	n					Juni		5 2006	, 0834 M
)	Examin		4a. Facility Name (If not institution	, give stree	t and nu	ımber)		4b. City	, Town, or	r Location	of Death		4c.	County of Deat	th _
		1	PENINSULA REGION	X ME	DIA	L CE	WER		540	1584	RY			Wicom	100
	Funeral		5. Social Security Number	6. Sex	.53.5		yrs. last birthdi	ay) If Under	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th	9. Birt	hplace (State or Foreign
	Director		215-26-2785	1 ☐ M	21 X F	77	Yrs	·	Duys	110013	771.	Feb.13		(Va.
	pu ,		Usual Residence of Decedent			100	City Tayon a	1							104 (
	within 72 hours after deeth with the Maryland ane. then "naturel", or items 23s or 28e-f ehow the Madical Examiliar must be mutilled at	_	10a. State 10b. County			100	c. City, Town or								10d. Inside City Limits
	86-1-6	Director	Md. Som	erset	t		Crisf	ield							1 XYes 2 No
	or 26	lre	10e. Street and Number					10f. Z	p Code				10g. Citi:	zen of What Co	ountry?
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	ee	Funeral	11. Marital Status	12. V		edent Ever		3. Was Deci	edent of H	lispanic Ori	igin? (Sp	ecify Yes or No Rican, etc.))-	14. Race - Ame Black, White	
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b	be file tal Hy d oth	Be	17. Father's Name (First, Middle,	Last)						18. Mothe	er's Nam	e (First, Middle	, Maiden	Surname)	
a	should be and Mental marked o	2	Clarence	Par	rsor	าธ				Ri	nni	e Sa	tch	el]	
Maryland	and and les mu		19a. Informant's Name/Relations		Print)		19b. M	ailing Addres	is (Street	and Numbe	er or Rur	al Route Numb	er, City or	Town, State, 2	Zip Code)
_	and 2 alth 27 (Richard D. B	rown	/ I	Husba	nd 4	Vill	age	driv	re A	pt.#27	Cr	isfiel	d, Md. 2181 Town, State
ē	of He of He f Item		20a. Method of Disposition			_	Cernetery, C	sposition (National Actions of the Control of the C	ame of other place	(e)		Date	20c. Lo	cation - City or	Town, State
Ë	Page ent c nt: If ry or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		val from	State M	ld. Vét	cerán	s Će	me.	6/2	0/06	Hu	rlock,	Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other then "naturel", or Items 23s or 28e-1 show any hours or other traumatic event, the Medical Examinar must be notified at DDGs.				1			22. Name a	nd Addre	ss of Facili	y Be	nnie S	m i + l	ı Fune	ral Homo
B	permit. Departr Imports eny inj		+ Physis	22. Name and Address of Facility Bennie Smith Funeral Home 917 W. Isabella, st. Salisbury, Md. 21801 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate											
	_		23a. Part1. Enter the disease, or	complication	ons that	caused the	death. Do not							bury,	Approximate
			shock, or heart failure. List Immediate Cause (Final	only one ca	use on	each line.			,						Interval Between Onset and Death
	Physician		disease or condition resulting in death)	_ a		VA									
1	/Medical Examiner		,		Due to	(or as a co	nsequence of):								
		er	Sequentially list conditions,	b	Dunk	47	nsequence of								
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89)	law requires that the death certifics ts been signed by the ettending ph 2 should be detached for use as t	Physician/Med	IF FEMALE:		,										
Вох	ath co	an/	23b. Was decedent pregnant in the past 12 months?	1	Live		Fetal death	3 □Ectopic _j		,			2	23d. Date of del Month	ivery Day Year
0.	e de	S	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Preg ⊒Unkr	nant at time nown	of death	5 Other (s	pecify)						July , July
Ρ.	at th	Æ				44. 1 4						20. 0:44			
	res tha igned be del	۵	Part II. Other significant condition	MIS CONTINDU	iting to c	beath but no	it resulting in th	e underlying	cause giv	en in Part I					the cause of death?
D.	w requir been si should	te										10	Yes 2L]No 3∏Pr	obably 4 🖾 Triknown
Records,	lawr as be 2 sh	ple										24a. Was		24b. Were au	topsy findings available completion of cause of
Œ	The ste h page	Completed										perfo	med?	death? 1 ☐ Yes	2□ No
Vital	en: rtifice	Be C	25. Was case referred to medica							26. Place	e of Deat	h (Check only o			
>	ysic is ce direc	To	examiner? 1 ☐ Yes 2 ☑ No	Hospi	ital:	Inpatient	2 ☐ ER/Outpa	tient 3 D	OA Oth	er: 4 □ Nu	ursing Ho	me 5 Resi	dence 6	Other (Spec	cifv)
o	g Ph er th eral		27. Manner of Death	28	Ba. Date	of Injury oth, Day Yea	ar) 28b. Time	e of	28c. Injun			28d. Describe I			,,
<u>.</u>	ath. r: Aft	atio	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	9	(10101	iai, Day 16	ar, mjui	м		Yes 2	No				
Division	Atta c de by th	2	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be	Be. Place	e of Injury - ling, etc. (S	At home, farm,	street, facto	ry, office			28f. Location (Street and	Number or Ru	ıral Route Number,
ā	alor afte Dir din	Certification;	4 Nomicide		Duild	ang, etc. (3)	респу)					City or To	wn, State)		
	spitus nours nere		29a. Certifier 1 Certifyir	g Physicia	n: To th	e best of my	knowledge, de	eath occurre	at the tin	ne, date an	nd place,	and due to the	cause(s)	and manner as	stated.
	• Ho • Fu • Fu	Medical	(Check only 2 Medical one)	Examiner:	On the b	basis of exa nner stated.	mination and/o	r investigatio	n, in my o	pinion, dea	ath occur	red at the time,	date and	place, and due	to the cause(s)
	To the Hospital or Attanding Physiclen: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifie	r						e number				e signed (Monti	h, Dey, Year)
	,- > 0	İ	1	0		7	00		400	57	41	0	61	15/	06
			30. Name and address of person	who comple	eted cau	se of death	(Item 23a) (Tu	ne Print)	y			mo e	/-/	/ /	<u> </u>
				20	Ton	F /	nemil	<+	51	ich.	11.1	MA	- 210	201	
	Sta	ete.	31. Date filed (Month, Day, Year)			Registrar's S	Signature	<i></i>	-W	100	19	11/4	218	U/	
	Registi		JUN 1	9 200E	5	ENBAR	· H	Charles	')						

DHMH 17 Rev 1/2001

Vermed Brown 215-26-2785

ORIGINAL

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Vivian Irene Belote 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month **Medical Examiner** June 18, 2006 1130 hrs ELOTE 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number 413 Priscilla Street Salisbury Wicomico 8. Date of Birth(MM/DD/YYYY) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or **Funeral** Months Davs Hours Min Director Country) М 220-78-676 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. Yes 2 No WICOMIC Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nnt: If item 27 is marked other than "natural", or items 23a or 28a-f sho are it friem 27 is marked other than "natural", or items 23a or 28a-f sho and it realmentic event, the Medical Lamingr must be notified at once. ISBURI MD Director 10e. Street and Number 10g. Citizen of What Country 2180 ISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Yes 3 Divorced If Yes, Give Year 1 Yes 2 No specify: Widowed Specify: 5 à 16a Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 DEMO LO 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number ABE 6 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 1 Burial 2 Cremation 3 Removal from State Important: OF DELMAR 4 Qonation 5 Other Specify minry or 21. Jignature of Funeral Service Vicenses 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Complications of diabetes Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. and trans Physician/Medical X UNPENDED After this certificate has been signed by the attending physician inneral director, page 2 should be detached for use as the burial -AMENDED item#23a.27.perME.g858.8/4/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth Ectopic pregnancy Fetal death Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 2 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes 2 No Director: After the in by the funeral Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the 1

30. Name and address of p who completed se of death (Item 23a) Deputy Chief Medical Examiner

2006

29b. Signature and title of confifier

31. Date filed (Month Car

and manner stated

111 Penn Street, Baltimore, MD 21201

29c. License number

OCME

29d. Date signed (Month, Day, Year)

June 27, 2006

OCMF 2006

State

			State of Maryland / Department of Health and 1- State State Per Verb., C856-Per 20/06/15/20/00/00/00/00/00/00/00/00/00/00/00/00/		giene	06	20766
			Decedent's Name (First, Middle, Last)	2. Date of De	ath		3. Time of Death
1	Physici /Medic		Gordon Hercher Berg	06/	′16√Ž006	Year	11:55 Pм
	Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	h	4c. County		
			Heritage Harbour Health Care Annapolis 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs	O Date of Bir		Arun	
H	Funeral Director		5. Social Security Number 6. Sex 1 M 2 G F 69 Yrs. last birthday 1 Months Days Hours Min.		1937		lace (State or Foreign stry) necticut
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	anylar	7	MD Anne Arundel Annapolis			1	0d. Inside City Limits 1 ☐ Yes 2 X No
-	the M	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of	What Coun	
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9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f ahow aumatic avent, Ita Madical Examinar must be notified at		1 □ Never Married 2 Married 1 □ Yes 2 M No If Yes, Give 1 □ Yes 2 No Specify:	to rican, etc.,		ck, white, v: Whi	
21215-0036	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of B		
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<u> </u>	should and Men	P		Charlott			
Maryland	d 2 sh th and 7 is n traun	H	19a. informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (Street and Number or Ring) Patricia Berg - Wife 2006 Quay Village Ct.		-		
	s 1 end 2 should if Health and Men Itam 27 is marke other traumatic		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location		
Ê			1 Burial 2 Micromation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 06/2	21/2006	Alexa	ndria	, VA
Baltimore,	permitPage Department of Important: if any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ad	vent Fun	eral &	Crema	tion Svcs.
<u> </u>	89889	X X	Falls Church,			s, MD	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.	,	rrest,		Approximate Interval Between Onset and Death
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× 6	thet the death certific ed by the attending p detached for use as	by Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d Da	te of delive	IN.
Box	death a atter d for u	lciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No			nth	Day Year
o.	of the c by the tacher	hys	9 Unknown				
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ord	w require been si should b	ted	Therenat Hourica	10,	Yes 2□No		abły 4 □Unknown
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ot	ding Physician: T. After this certific funeral director,	H-1	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		how injury occur		'/
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	pital ours a neral [29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	and due to the	cause/s) and ma	nner as st	atad
	To the Hoepital within 24 hours a To the Funeral I completely filled	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence)	urred at the time,	date and place,	and due to	the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier 29c. License number	Ciar	29d. Date signe	d (Month, I	Day, Year)
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	4		30. Name and address of person who completed cause of de th (Item 23a) (Type, Print)	yolo of	int al	エス	D42
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature	v en		7	- 10.
	Registi		JUN 3 0 2006 Kinger Br Specker				

State of Maryland / Department of Health and Mental Hygiene > (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 14 00:31 JUNE 2006 /Medical Grace Anne Burdette 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKins OhAK If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Euneral** Days Months Hours 1 ☐ M 2 💢 F Director None June 13. 2006 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Madical Examiner must be notified at 1 Yes 2 □ No Director WV Berkeley Martinsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 495 Olympic Drive 25401 USA Completed by Funeral 12. Was Decedent Éver in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Itel Never Married 2 Married 3 Widowed 4 Divorced Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Colfege (1-4or 5+) N/A None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Benjamin Joseph Burdette Wendy Michelle Jeffries 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Ie m any injury or other traum r 495 Olympic Drive - Martinsburg, WV 25401

20b. Place of Disposition (Name of cometery, crematory or other place)

Date 20c. Location - City or Town, State Benjamin J. Burdette - Father 20a Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/21/06 Edge Hill Cemetery Charles Town, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eackles-Spencer Funeral Home Kole M970 scem Harpers Ferry, WV 25425 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1 (150my 1 ou resulting in death) /Medical Due to (or as a consequence of): Examiner Congenitul heart anamal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (se as a consequence of): Examiner ig physician and as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medicai *IF FEMALE* 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pg 2 No 3 Probably 4 Unknown 1 Yes Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 🗆 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director. 25. Was case referred to medical examiner? Be 26. Pface of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Mfnpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of centifier 63 14, 2006 on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 600 31. Date filed (Month, Day, Year) WOLFE Baltimore, MD State JUN 19 2006 Registrar

		1	- State Amend #1 P	State o	f Mary 857 7	vland / Dep //31/06 Ca	artment of H	lealth and Death		giene) () Reg. No.	06	207	168
Physi	cian	ı	Decedent's Name (First, Middle, La	^{ist)} Jan		rgaret	Clements		2. Date of Dea	ath Day	Year	3. Time of I	
	dical		Tan Marg			ements	1		June		2006	8:20) p ^M
Exan	niner	4	Ia. Facility Name (If not institution, gi				4b. City, Town, or		ath	4c. Count	y of Death		
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yland			10a. State 10b. County		10	c. City, Town or l	ocation					10d. Inside City	y Limits
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or 28	Director		10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	ntry?	
2-UUSO 72 hours after deeth with the Maryland natural; or items 23s or 28s-f show disal Examiner must be notified at			8205 Lapping Bro	ok Court				723		US	SA _		
r dec	Funerai		11. Marital Status	12. Was Dec	rces?	r in U.S. 13	Was Decedent of H If Yes, specify Cuba	ispanic Origin? In, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Ra Bla	ce - Ameri		
s afte	by Fi		1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Gi	V8		1 ☐ Yes 2 🖾 No	Specify:		Speci	y: Wh:	ite	
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y carry	5		Edward Davis					Jannie	e Matthew	S			
4 48 5 1 1	-		19a. Informant's Name/Relationship	(Type, Print)		19b. Mai	ing Address (Street	and Number or I	Rural Route Numbe	r, City or Towr	, State, Zip	Code)	
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permit. Pag Department Important: any injury o	ġ		21. Signature of Funeral Service Lice	nsee		2	22. Name and Addres	ss of Facility				VA 2	201.70
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death certifications of for use as	Physician/M		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out						23d. Da	ate ol delive	ery	
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Metely	Medical		(Check only 2 Medical Exa	miner: On the b and man	asis of exa ner stated	amination and/or i	th occurred at the tim nvestigation, in my op	pinion, death oc	curred at the time, o	date and place	and due to	the cause(s)	
To the Hospital or within 24 hours eff To the Funerel Discompletely filled in	Me	-	29b. Signature and title of certifier	010	11		29c. License	number		29d. Date signe	ed (Month,	Day, Year)	
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10		-	30. Name and address of person who	. (1			N		1	0	10
V			RANDALL	WAG		1	20 CM	Laou	1-106	AKON	MA	rk,	MD
Regi:	State		31. Date filed (Month, Day, Year) JUL 3 - 200		legistrar's	Signature	160		•		1	x	
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			For State Registrar	State of	Marylan		artment rtificate			ind M		giene ()	06	20769
	Physicia	an	1. Decedent's Name (First, Middle	e, Last)	_						2. Date of Dea Month	ith Day	Year	3. Time of Death 5:00PM
	/Medic	al	Samuel T. (nhos)		4b. City, To	OME OF	Location	f Dooth	June 9	2006 4c. County	of Death	3.00/ M
	Examin	er	4a. Facility Name (If not institution Bayside Care	-	iber)				ton P				Mary	15
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1				8. Date of Birth (Month, Day	2	/ -	place (State or Foreign
	Director		579-18-0588	½ M 2□F	93	Yrs.	Months	Days	Hours	WIIII.	June 4,	1913	Ash	ville, N.C.
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation			-				10d. Inside City Limits
	Maryl	tor	DC None		Ws	ashing	ton							1 X Yes 2 ☐ No
	n the	irec	10e. Street and Number				10f. Zip C	Code				10g. Citizen of	What Cour	ntry?
	23a c	alD	1321 Talbert	Terr. S.	Ε.			020				Unite		
	tams rerm	nue	11. Marital Status	Armed For		S. 13.	Was Deceder If Yes, specify	nt of His y Cubar	spanic Orig n, Mexican	jin? (Spe , Puerto	cify Yes or No- Rican, etc.)	14. Rad Blad	ce - Americ ck, White,	can Indian, , etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Mar 3 ② Widowed 4 ☐ Divorced	If Yes, Giv	е		1 ☐ Yes 2X	No 🗘	Specify:			Specif	v: B1	lack
9	2 hou	ted	15. Deceder	nt's Education		16a. Dece	dent's Usual	Occupa	tion	of worki	na	16b. Kind of B	usiness/In	ndustry
21215-0036	ithin 7 ne.	Completed	Elementary/Secondary (0-12)	st grade completed) College (1	-4or 5+)		kind of work DO NOT use eman	retired)	uning most	01 110/1/1	9	Librar	v Of	Congress
2	filed within 72 hours after death with the Maryland Hygiene. ther than "natural; or itams 23e or 28e-f show ent, the Medical Evantral must be rediffed a	Cor	17. Father's Name (First, Middle,	l ast)		FOI	Cinaii		18 Mothe	r's Name	(First, Middle,	······		Congress
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural; or items 23a or 28a-f show apprint introduction to the transportant of the transportant in the Medical Evantual must be rediffied at once.	To Be	Unknown						Unk	cnowr	1			
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o L	ages ent of hit: If i		1 ⊠Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (matory or oth lemoria		em.	6/17	7/06	Suitla	and,	Md.
Baltimore,	epartme epartme nportar ny injur		21. Signature of Funeral Service	Licensper			2. Name and Austi	in D	OTTETE	Tr Tr	ıneral H			
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			shock, or heart failure. Lis	t only one cause on e	ach lin	. Do not sin	A	or dynig	+	7)	A A	1031,		Interval Between Onset and Death
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0.	or 는 # #	Physician/Medical	1 Yes 2 No	4□Pregn 9□Unkno	ant at time of de own	eath 5	Other (spec	cify)						
<u>α</u>		by Ph	Part II. Other significant condit	ons contributing to de	eath but not resu	ulting in the u	nderlying cau	use give	n in Part I.		23e. Did to	bacco use cont	ribute to t	the cause of death?
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ion	Attending F r death. sctor: After by the funer	atlor	1. Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Moni igation	th, Day Year)	Injury	м	Work 1 □ Y	? ′es 2 🗆 l	No				
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		Σ	29b. Signature and title of certifi	710	011		29c.	License	number	111	(C)	29d. Date signe	d (Month,	Day, Year)
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			30. Name and address of person		24035 T			SO=4	นุกไ] < 17.20	U FOO	20636		
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year JUNE 13, 2006 11:02 AM **Physician** CARTER MARGARET /Medical 4c. County of Death
PRINCE GEORGE'S 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** 1 M 2 TKF Virginia 31, 61 May 230-62-9082 Director Usual Residence of Decedent 10d. Inside City Limits deeth with the Maryland 10h. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, II.a Medical Examinat must be recitified at 90ce. 10a. State 1√⊋Yes 2□No Prince George's Temple Hills Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20748 United States 2608 Iverson Street 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black Specify Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 € Divorced þ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Government Postal Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 Catherine Carter Raymond Freeman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 312 Washington Va 22747 Mary Groves /Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Odd Fellows Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition ows Cemetery June 17, 2006 Washington Va 22. Name and Address of Facility POPE FUNERAL HOME MXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Ligense 2617 PENN AVE SE WASHINGTON DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Advanced Cancer of unclear orgin 17140-**Physician** /Medical Due to (or as a consequence of): Examiner Congestive heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Physician/Medical Examiner 21 The law requires that the death certificate be executed use es the burial-transit Septice min Due to (or as a consequence of): ettending physicien for use es the buria Box 68760, IF FEMALE: 23d Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death in the past 12 months? 5 Other (specify) been signed by the should be detached Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 : has 1 ☐ Yes 2 No 1 Yes 2 📉 No certificete ospital or Attending Physicien: Thours after death.
uneral Director: After this certificel if filled in by the funeral director. p 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 🖾 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ဥ 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Mospital of 124 hours al 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Funerai Medical (Check only one) within 2 To the the th 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 1) 43446 suit Ful M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Are suit 3-41 Silver Spring MD 20902 M.D. ROINTAN FARAHIFAR 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JUN 1 9 2006

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I	Physicia	an	1. Decedent's Name (First, Middle, Last) Joseph Philmore Cla			2.	Date of Death		3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)	1 у	4b. City, Town, or Loca			Day Year 5 2006 4c. County of Deat	
	Examin Funeral Director	er	Frederick Memorial 5. Social Security Number 6. Sex 7. Age $216-30-3957$	(In yrs. last birti	tal Freder	Cick Under 24 Hrs. 8.	Date of Birth (Month, Day, Ye	Frede	
3	Nand Nand		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	e Mary	ctor	Maryland Frederick	Moun	t Airy				1 ☐ Yes 2√2 No
4	Min in	Dire	10e. Street and Number 13909 Penn Shop Road		10f. Zip Code 21771		10g.	Citizen of What Co	untry?
	ma 23	Funeral Olrector	11. Marital Status 12. Was Decedent E	ver in U.S.	13. Was Decedent of Hispan If Yes, specify Cuban, Me	ic Origin? (Specify	Yes or No-	14. Race - Ame	
2	permit. Pages 1 and 2 should be filed within 72 hours after deeth with frie maryland Depertment of Health and Mential Hygiene. Depertment of Health and Mential Hygiene. Insportment if firm 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer traust be notified at once.	þ	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Narried 1 Yes, Give Year or Dates:	° Korea		exican, Puerto Rica	an, etc.)	Specify: W	oite
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7	iene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+	F)	wner/Operator			ntractor	lial y
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<u> </u>	d Ment narks natic s	2	Adolphus Clay 19a, Informant's Name/Relationship (Type, Print)	10h	Mailing Address (Street and N	Louise	Watki		Tip Code)
	Ith and 2 St is not traum		Georgia W. Clay - Wife		3909 Penn Sho				
ָט ב	of Hea of Hea of Hea of Hea of Hea		20a. Method of Disposition	20b. Place of	Disposition (Name of y, crematory or other place)	Date		Location - City or	
	ment tent: if tent: if jury o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify)		mery Methodis		06 Da	mascus, 1	Maryland
Dal	Departing Sany In 2000.		21. Signature of Fulleral Service Excenses	ms	22. Name and Address of Molesworth-W: 26401 Ridge	2112 - T	A., Fu	neral Hor	ne 1 20872
			23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line	the death. Do n	ot enter the mode of dying, such	ch as cardiac or re	spiratory arrest,	nar y zam	Approximate Interval Between Onset and Death
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L (cp.	quires that en signed t	by	Part II. Other significant conditions contributing to death but	t not resulting in	the underlying cause given in	Part I.		coluse contribute to	the cause of death?
י שפר ו	The law re cete hes be page 2 sho	Completed					24a. Was an autopsy performed	prior to o	topsy findings available completion of cause of 2 No
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5	or this	n; To	27. Manne of Death 28a. Date of Injury	/ 28b. T	patient 3 DOA 4		Describe how in	6 ☐Other (Specially occurred	erfy)
5	eath. or: Aft	catlo	2 Accident investigation		M 1 ☐ Yes	2 No			
	s after d al Direct ed in by	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur building, etc.	y - At home, far (Specify)	m, street, factory, office		Location (Street City or Town, St.	and Number or Ru ate)	ral Route Number,
	To the flooptial or Atlanding Prysician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier Certifying Physician: To the best of Check only one) Certifying Physician: To the best of and manner state	examination and	, death occurred at the time, da t/or investigation, in my opinion	ate and place, and n, death occurred a	due to the cause it the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	Veith Common	Σ	29b. Signatule and title of certifier		29c. License num		290.1	Date signed (Montl	n. Doy, Year)
0	+11/1		30. Name and address of person who completed cause of de Hemen shah, 65 G	57)	-1	r. Fre	devicie	MDZ	1702
	Sta Registr		31. Date filed (Month) DNY 2006 32. Expistrar	r's Signature	Johnson D				

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 06 Physician James Daniel Cooper 06 2006 8:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 85 Yrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthptace (State or Foreign Country) **Funeral** 229-14-5245 Director 11-28-1920 Virginia Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland yent of Heelth and Mental Hygiene. Intended them 27 is marked other then "natural", or Items 23e or 28e-f show 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 7 is marked other then "natural", or items 23e or 28e-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1838 Maryland Ave. N.E. 20002 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Cottege (1-4or 5+) 12 Administration U.S. Govt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Cooper Maggie LAw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Cooper/Niece 921-B Randolph St. N.W. Wash., D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Pege Depertment of Important: if eny Injury or once. Ft. Lincoln 4 □ Donation 5 □ Other (Specify) 06-16-06 Brentwood, Md. 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3831 Georgia Ave. N.W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Wash., D.C. 20011 Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Arrest **Physician** /Medical Due to (or as a consequence of): Examiner Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Chronic Renal Failure Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Physi 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nes been siç s 2 should t 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificete hes autopsy performed? page 1 ☐ Yes 2 ☐ No 1 Yes 2 XNo Be (25. Was case referred to medicat 26. Place of Death (Check only one) Hospital: 1 ☐ tnpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) t ☐ Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation М 1 □ Yes 2 □ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funerel D completely filled in the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and tiffe of certifier 29d. Date signed (Month, Day, Year) 2 RIOKS D46529 June 14,2006 of person who completed cause of death (Item 23a) (Type, Print) 4115 Wilkens Avenue Victor Onyejiaka Baltimore, MD 21229 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State JUN 16 2006 Registrar

			For State Registrar	State	of Maryla		artment of Hartificate of I		d Mental H	ygiene . Reg. No.	2006	20773
			Decedent's Name (First, Middle	, Last)					2. Date of I	eath		3. Time of Death
н	Physici		Victorine Adel	lino Card	in				June	Day 15	2006	8:45 A ^M
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, or	r Location of De			County of Deat	
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	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Year	If Under 24 h				hplace (State or Foreign untry)
	Director		043-01-6419	1 ☐ M 2 🖾 F	10	4 Yrs.	Months Days	Hours M	Min. (Month, I			de Island
	ס		Usual Residence of Decedent									
	how	_	10a. State 10b. County		10c. C	City, Town or Lo	cation					10d. Inside City Limits
	Ma 9-1-8	cto	Maryland Montgo	omery	5	Silver S	pring					1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Co	untry?
	23a		10922 Inwood Av	zenue			2	0902		USA	A	
	dea	Funeral	11. Marital Status		cedent Ever in orces?	U.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or I	No- 1	4. Race - Ame Black, Whit	
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Maryland 21215-0036	ljed v tygie her t		17. Father's Name (First, Middle,	(act)		Offic	e Manage		Name (First, Mido		artment	Store
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ğ	See Figer		1 X Burial 2 ☐ Cremation		n State	cemetery, crer ate of H	natory or other plac	(e)	54.0	200. 200	ation - Oity of	TOWII, State
≣	tant Jury		4 Donation 5 Other (S				Cemete	ry Jun	1.19,2006	Silve	r Spri	ng,Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show sary injury open treumatic event, the Medical Examinar outsi, be notified at once.		21. Signature Funera Service	Licensee	20	Fr	ancis J.	collin	s Funera	1 Home	e, Inc.	
_	461 4 4		- Curoller	To		50	O Univer	sity Bl	<u>vd.,W.,S</u>	<u>ilver</u>	Spring	,MD 20901
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	each line.	ath. Do not ent	er the mode of dyin	ig, such as care	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resolding in death)	Due to	o (or as a conse	equence of);						
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	ed sit	Examiner	dany, leading to immediate cause. Enter Underlying Cause (Disease or injury	- Due to	THE SECURE	acjuence-urj						
	and J-trar	хап	that initiated events resulting in death) Last	c. Due to	o (or as a conse	equence of):						
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×	death certiff e attending id for use es	/We	IF FEMALE:	23c. If yes, o	utcome of preg	nancy				25	3d. Date of del	nen.
B	atter for u	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	binth 2 ☐ Fe gnant at time of	etal death 3	Ectopic pregnancy Other (specify)	'		-	Month	Day Year
P.O. Box	that the death certif ed by the attending detached for use e:	ysi	1 □ Yes 2 🖾 No 9 □ Unknown	9□ Unk								
	es that igned by be deta	by Physician/Me	Part II. Other significant condition	ons contributing to	death but not re	esulting in the u	nderlying cause giv	en in Part I.	23e. Dio	tobacco us	e contribute to	the cause of death?
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न		e Co	25. Was case referred to medical						1 ☐ Yes		1 🗌 Yes	2□ No
₹	Physician: r this certificanal director,	o Be	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatien	Oth	oc	Death (Check only		F10 (0	Hospice House
Division of	<u>e</u> = <u>e</u>		27. Manner of Death	28a, Date	e of Injury	28b. Time of	I JU DOA	4 U Nursin	g Home 5 Re			Hōtisē
o	ding Phy h. After thi funeral	ţ	1 Natural 5 Pendin 2 Accident investig	g (Mo	nth, Day Year)	Injury	28c. Injun Worl	k? Yes 2 ☐ No		,		
īs	Attending r death.	fica	3 ☐ Suicide 6 ☐ Could	not be 200 Plac	ce of Injury - At	home, farm, str	eet, factory, office		28f. Location	(Street and	Number or Ru	ıral Route Number,
á	after Dire	Certification:	4 Homicide	buil	ding, etc. (Spe	cify)			City or T	own, State)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	alc	29a. Certifier 11X Certifyin	g Physician: To the	ne best of my k	nowledge, death	occurred at the tim	ne, date and pl	lace, and due to th	e cause(s) a	and manner as	stated.
	Ho 124 h	edical	(Check only 2 Medical one)	Examiner: On the and ma	basis of examination of the contract of the co	nation and/or in	estigation, in my o	pinion, death o	ccurred at the time	e, date and p	place, and due	to the cause(s)
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	1,14)	Childe	Guno.			D 4	2452		June	15, 20	06
			30. Name and address of person	who completed ca	use of death (It	em 23a) (Type,				0 0110	-3, 20	
			Chitra Rajagor				ter Mill	Rand	Rockvil	le Mar	bacty	20850
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	Registi	rar	JUN 16	2006	Ever &	shature						

		-	For State Registrar	State of Ma	ryland /		artment of H tificate of L			giene Reg. No. 2006	20774
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	/Medic Examin		4a. Facility Name (If not institution, give s		DOLYB		4b. City, Town, or	Location of Death	June	25, 2006 4c. County of Dea	000011
	Z.Xaiiiii	•	2 Colonial Manor C	ourt			E1kton			Cecil	
	Funeral		5. Social Security Number 6. Sex	7. Age M 2 ☑ F	(In yrs. last	b <i>irthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 2,		thplace (State or Foreign ountry)
	Director		220-12-5600 Usual Residence of Decedent		00				Dec. 2,	, 1917 De	laware
	how		10a. State 10b. County		10c. City, To	own or Lo	cation				10d. Inside City Limits 1 X Yes 2 □ No
	8a-f	Director	Maryland Cecil			E1k	ton			10g. Citizen of What C	127/
	with the or 2	Dir	10e. Street and Number 2 Colonial Manor C	lourt.			10f. Zip Code	921		United	•
	death	Funerai		12. Was Decedent E Armed Forces?	ver in U.S.	13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (St	pecify Yes or No-		erican Indian,
36	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or itema 23e or 28e-f ahow any njury or other traumatic evant, the Medical Evantinar must be notified at ano.	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 反 N If Yes, Give	io		1 □ Yes 21√2 No	Specify:	7 110411, 0101,	Specify: W	
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Baltimore, Maryland 21215-0036	abe fil	Be c	17. Father's Name (First, Middle, Last) Alyk Borys						ne Gera	Maiden Surname)	
Ž	should nd Me mark mark	ဥ	19a. Informant's Name/Relationship (Ty)	pe, Print)	1	9b. Mailir	ng Address (Street a			er, City or Town, State,	Zip Code)
N.	and 2 alth a 27 is		Jean Moran/Daughte	r		The later of the l	W. Thomso	on Drive,			
ore	of He of He if item or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R	emoval from State	ceme	tery, crei	sition (Name of matory or other plac		Date	20c. Location - City o	
tim.	t. Peg rtment rtent: njury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		Immacu		Conception Name and Addres	The second second second	1,2006	Cherry Hil	1, Maryland
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			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused re cause on each lin	the death. D	o not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
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	/Medical Examiner			Dug to (of as a	a consequent	ce of):	Lir Con	dina	scular	1 Disease	lur
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	consequen	ce of):	(A)	1000	5(0)	10100-101	7-7-
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9	tificate ng phys as the	0	IE EENALE.	118							
Вох	eath certific attending p	lan/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 Live birth	2 Fetal de	ath 3[Ectopic pregnancy			23d. Date of de Month	elivery Day Year
0.	at the de by the a stached f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	1 5	Other (specify)				
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lal		e Co	25. Was case referred to medical					26 Place of Dea	1 ☐ Yes	2 No 1 Ye	s 2 No
Į Š	\$ e 5	To B	examiner?	Hospital: 1 ☐ Inpatie	nt 2 ER	/Outpatie	nt_3 DOA Oth	er	ome 5 Resid		ecity) LIVING
n of	ding Ph h. After th funeral		27. Manner of Death 1 Houral 5 Pending	28a. Date of Injur (Month, Da)	ry 28 Y Year)	b. Time o Injury	Wor	k?	28d. Describe I	how injury occurred	
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Ö	s efter	Certification:	4 Homicide determined	building, etc			,,		City or Tov	wn, State)	
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	To the To the Comp	ž	29b. Signature and title of certifier	0			29c. Licens	e number		29d. Date signed (Mor	ith, Day, Year)
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	10		Barbara A. Parey,	100 000				+~ 01/	E11.	MD 21921	
	St	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature		reet, Sui	re 214,	<u>Likton,</u>	MD 71371	
4	Regist	rar	JUL 3 - 2006	18 Billion	18. J	A234	a d				

		1 - State Registrar	State of Maryl		artment of h <i>tificate of</i>			giene 2006	20775
THE WALL	49	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	nth Day Year	3. Time of Death
Physic		Katharine Tenni	lson Dev	1in			June 14		6:30 P M
/Med Exami		4a. Fecility Name (If not institution, give st.			4b. City, Town, o	or Location of Deat	h	4c. County of Deat	1
LAUITI	1	3505 Toddsbury Lane			Olney			Montgome	ry
Funera		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year		8. Date of Birth	9. Birtl	nplace (State or Foreign
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·		Usual Residence of Decedent							
yłan how		10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
Marie S	Ş	Maryland Montgomery	C	hevy Cha	se				1 ☐ Yes 2 X No
h the	je je	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
th wil	a D	8101 Connecticut Av	enue, #C50	2	20815			United Sta	tes
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or ite	正	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2 🖾 No			Spacify:	
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VIBNG 21215-UU30 und be filed within 72 hours after death with the Marylan Mental Hygiene. arked other than "naturel", or Itema 23e or 28e-f show atte event, tre Medical Examinar must be inclifted at	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
Via Men Men Arke	2	Zachariah B. Lloyd				1	n Hammer		
Mar nd 2 sh lth and 17 is m		19a. Informant's Name/Relationship (Type Diane D. Keefe/ Date						or, City or Town, State, 2 aryland 208:	
		(<u> </u>		Ob. Place of Dispo		y Lane,	Date Date	20c. Location - City or	
Baltimore, bermit. Pages 1 ar Department of Hea mportant: if item any injury or othe		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re		centery, cred	1214 et ether pla	Jur	ne 17,	200. Location - City of	TOWN, State
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		23a. Part1. Ehrer the disease, of complice shock of heart failure. List only one	ations that caused the cause on each line.	death. Do not ent	er the mode of dyi	ing, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
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/Medica		resulting in death)	Due to (or as a co	nsequence of):					
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rtificant		IF FEMALE:							
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. 0 00	10	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 Pregnant at time 9 Unknown	of death 5	Other (specify) _				
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v require	ted						1,11	195 24ENO 3[[FI	obably 4 Dolkhown
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hysic nysic nis ce	2	1 ☐ Yes 2⊠ No	ospital:	2 ER/Outpatier	II 3LI DOA		Home 5 Resid	dence 6 KlOther (Spec	in Residence
on of		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o	Wo		28d. Describe h	now injury occurred	
SiO endii or: A he fu	atic	2 Accident investigation			M 1	Yes 2 No			
Division of Vital Records, or Attending Physician: The law requires the death. Director: After this certificate has been signe in by the funeral director, page 2 should be	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	reet, factory, office	1	28f. Location (S City or Tox	Street and Number or Au vn, State)	ral Route Number.
Lisafi ret Di	Cer		77.						
Hosp 4 hou Funel	edical	(Check only 2 Madical Examin	ar: On the basis of exa					cause(s) and manner as date and place, and due	
Division of Vital Voltal with Hospital or Attending Physician: within 24 hours after death. To the Funeret Director: After this certifical completely filled in by the tuneral director.	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen	ise number		29d. Date signed (Monti	h, Day, Year)
E ME			N	<u> </u>	DE	2711			
20		30. Name and address of person who cou				3711		June 15, 20	000
		Pasquale Santini,				hevy Chas	se. MD 20	0815	
Single of C	tate	31. Date filed (Month, Day, Year)	32 Registrar's			cvy Onas	, 1111 20	,010	
Regis		JUN 19 200	ALC:	Signature	wes				

		1	For State Registrar	State of Maryland / Depa Cel	artment of Health and N rtificate of Death	ental Hygien/ Reg. N		20776
			Decedent's Name (First, Middle, Last)			2. Date of Death Month D	ay Year	3. Time of Death
	Physicia /Medic		Margot A.	Deoro			, 2006 Year	2:45p M
)	Examin		4a. Facility Name (If not institution, give str		4b. City, Town, or Location of Death	4	c. County of Death	
			11305 Ashley Dr	7. Age (In yrs. last birthday)	Rockville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgor	place (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex	4 2 XF 82 Yrs.	Months Days Hours Min.	5/31/192	r) Cou	uba
			Usual Residence of Decedent			3/31/172		
	Maryland f ehow	ō	10a. State 10b. County Montgome	ery Rockvil				10d. Inside City Limits 1 ☐ Yes 2 No
	death with the Maryland rms 23a or 28a-f ehow	Direct	10e. Street and Number 11305 Ashley Dr	rive	10f. Zip Code 20852		Citizen of What Cou	intry?
•	be filed within 72 hours after death with the Marylan ital Hygiene. ad other than "natural", or Items 23a or 28a-f show event, the Madical Examinar must be notified at	Funeral Director	11. Marital Status 12 1 Never Married 2 Married	1 ☐ Yes 2 X No	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	_	14. Race - Amer Black, White	, etc.
2-0030	tural, o	þ	3 XWidowed 4 □ Divorced 15. Decedent's Education	If Yes, Give Year or Dates: ation 16a. Dece	1⊠ Yes 2 □ No Specify: Cu	16b.	Specify: V Kind of Business/li	Vhite ndustry
017	within 72 hours after ene. than "natural", or Ite he Medical Exemina	Completed	(Specify only highest grade Elementary/Secondary (0-12) 1 2	College (1-4or 5+)	s kind of work done during most of wor DO NOT use retired) Dmemaker	king	Own Ho	ome
0	buld be filed of Mental Hygis arked other atic event, II	Be	17. Father's Name (First, Middle, Last) Angel Blanco			ne (First, Middle, Maide na Arias	en Surname)	
Maryi	permit. Pages 1 end 2 should be Depertiment of Health and Mental important: If item 27 is marked any injury or other traumatic evonce.	2	19a. Informant's Name/Relationship (Type Clara T.Stephens		ing Address (Street and Number or Ru			
ē,	Health Com 27		20a. Method of Disposition	20b. Place of Dispo	osition (Name of	Date 20c.	Location - City or T	
saitimore,	Pages ment of ant: If i		1 ☐ Burial 2 【A Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State Chesar	peake Crem 6/16			ville,Md
n D D	Depertiment important in sonce.		21. Signatus Funeral Service Cont	9	SHTLTP ^{ad} DS RTNALD 241 Columbia B	lvd.Silve	SERVIO er Sprin	CE, P.A. ng, Md20910
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition		iter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	NAL FAILURE			IYOAN
	be sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of): ANTI'N	, , , = , - : =			107EANS
8760,	icate be executed physicien and s the burial-transit	i Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of): BREAST	CANCER			1576M1
	physic the t	dicai	d.					
. Box 6	To the Hospitel or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificete has been signed by the attending F completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
<u>Р</u>	hat the ed by th detache	Phys	9 Unknown Part II. Other significant conditions confi		underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
rds,	quires (an signe	ed by	CWITNIDA	in DIFFICILE DIAITE	ney	1 ☐ Yes	2 🗹 No 3 🗆 Pro	obably 4 Unknown
Reco	the law re te hes be ege 2 sho	Completed				24a. Was an autopsy performed?	prior to o death?	topsy findings available completion of cause of
ta	an: Trifice	a)	25. Was case referred to medical		26. Place of De	ath (Check only one)		
Division of Vital Records, P.O. Box	ng Physici ter this ce neral direc	on; To B	examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	ospital: 1 Inpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work?	lome 5 Residence 28d. Describe how in		ufy)
visio	r Attendit er death. rector: Al	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, Str	and Number or Ru ate)	ral Route Number,
٥	ospitel o hours aft uneret Di ly filled in		29a. Certifier 1 Cartifying Phys	ician: To the best of my knowledge, dea ar: On the basis of examination and/or i	ath occurred at the time, date and place	a, and due to the cause	(s) and manner as	stated.
	the Hi nin 24 the Fu	Medical	one)	and manner stated.	29c. License number		Date signed (Monti	
	To To con	2	29b. Signature and title of certifier	7	D 29256		June 16,	
	5		30. Name and address of person who co		a, Print) Lgomery Avenue	Betheeds	Md 2001	4
	Si Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signature		-cenesua,	114 ZUO	4

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Year 7:37 P M JUNE 15 2006 THEARL ELIZABETH DYKES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Director 220-40-2440 65 Jan. 17, 1941 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County Worle 10d. Inside City Limits r then "natural", or itame 23a or 28a-f ehovine Medical Examiner must be notified at Yes 2 No Maryland Frederick Brunswick Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 West I Street 21716 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other then Elementary/Secondary (0-12) College (1-4or 5+) 11 Housekeeper Domestic permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any link you other traumatic event pies. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles A. Dykes Lucille Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Ramey / Daughter 105 Norwick Court, Frederick, MD 21702 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ဩBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gardens 6/21/2006 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1100 North Maple Ave., Brunswick, MD 21716 23a. Part. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE HEART FAILURS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Detail death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 3 Probably 4 Unknown 2 🗆 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has b autopsy performe 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending after death.

Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 24 hours a Hospital Medical 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-57796 SUNC 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 West 7th Street, Frederick, MD 21701 Lalit Verma, M.D. egistrar's Signature 31. Date filed (Month, Day, Yaar) 2006 State Registrar

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Division of Vital Records, P.O. Box 68/60,	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.	Funeral Director. After this certificate has been signed by the attending physicien and setely filled in by the funeral director, page 2 should be detached for use as the burial-transit
Division of Vital	Hospital or Attending Physician: The Hours after death.	Funeral Director: After this certificate

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	/Medic		4a. Facility Name (If not institution		number)		4b. City, Town,	or Location of C			4c. County of	Death	301111
	8	42	Calvert County		_		Prince F				Calver	:t	
	Funeral Director		5. Social Security Number 220–34–3443	6. Sex 1 □ M 2 🙀 F	-	93 Yrs. last birthday	Months Days		Min.	Date of Birth (Month, Day, Y	ear)	Coun	**
P	2150		Usual Residence of Decedent 10a. State 10b. Count	·		10c. City, Town or I				aii 24 1	913		ginia
Maryla	f eho	ŏ	Maryland Calv	•		Prince F						1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
the !	r 28a-	Directo	10e. Street and Number				10f. Zip Code			10g	j. Citizen of Wh	at Coun	
ath wit	23a o		1046 West	field Dri	ve		20678				United	Sta	tes
-UU36 hours after death with the Maryland	el', or items 23a or 28a-f ehow Examiner a dat be nullieu at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	rned 1 Tye	Forces?		. Was Decedent of F If Yes, specify Cub 1 ☐ Yes 2 2 No	an, Mexican, F	n? (Specify ⊇uerto Rica	Yes or No- an, etc.)	14. Race - Black, Specify:	White,	
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N D	Hygie other ent.		17. Father's Name (First, Middle	3 , Last)		Regis	tered nur		Name (Fi	irst, Middle, Ma	ealth c	are	/hospital
yland buld be file	tic s	To Be	William Henry	y Childre	SS			Carr	cie Ho	oughton			
she she	is ma reuma		19a. Informant's Name/Relation Angela Jean Alv		augh		ling Address (Street						
	f Health item 27 other tr		20a. Method of Disposition		augi.	20b. Place of Disp	Westfield	- 1	Pate		C. Location - Cit	_	_
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Baltimore,	Department important: ff any injury or once.		21. Signature of Funeral Service	License			22. Name and Addre	es of Facility			ral Hom		LIGHTED
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on ding	ith. :: After e fune	ation	1 ➡Natural 5 ☐ Pendi		onth, Da	Year) Injury	Wor	yal k? Yes 2 □ No		Describe how	injury occurred		
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o the	within 2 To the comple	Med	one) 29b. Signature and title of certific	and m	anner sta	ated.	29c. Licens				Date signed (A		
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,	5		30. Name and address of persor		use of d	eath (Item 23a) (Type	Print)					1.0	100
1,	5 Sta	te.	31. Date filed (Month, Day, Year	WEIG) 32	Registra	ar's Signature	RWCE	rre	DER	ICK,	m)	م کے 0	6 15
	Registr	_	JUN 19	2006	Ross	ar's Signature	arts)						

		For State Registrar	State of Maryl		artment of H <i>rtificate of L</i>			giene /	2006	20779
Physici /Medic		1. Decedent's Name (First, Middle, Last) CHRISTIAN	ANDR	EW	D	'ANNA	2. Date of Dea Month June	Day	Year 2006	3. Time of Death
Examin Funeral Director	er	5. Social Security Number 6. Sec	okins Hoe	pital yrs. last birthday) 58 Yrs.	Baltin	Location of Death C If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat Sept • 18	h	9. Birthp	olace (State or Foreign http://
tand Dw		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	ocation				1	0d. Inside City Limits
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perillingie; Mai yiailia 212.30000 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of health and Mental Hydiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event. Its Medical Examinar must be notified at ance.	Funeral	9919 Pine Tree Roa 11. Marital Status 1 □ Never Married 2 ™ Married	Oliver or Dates:	in U.S. 13.	217 Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☑ No		pecify Yes or No- Rican, etc.)	. 14	ted Sta Race - Americ Black, White,	ean Indian, etc.
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and 2 s and 2 s alth ar 27 is er trau		Barbara D'Anna / W	ife		Pine Tree			MD	21798	
mit. Pages 1 a partment of He portant: If item y injury or oth 62.		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State		matory`or other plac thaven	" ¦ Jun	Date 12, 2006		ation - City or To	own, State
Demit. Department in processing the processing to the processing t		21. Signature of Thurs Savedy Licens		R ²	2. Name and Addresses thaven 1501 Catoci	s of Facility Funeral S tin Mtn.	ervices	, Skk	ot Cody	P.A.
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prior to completion of cause of death 1 98 25 No 28	e la bla		Hypertension Oste	oporosis. Thr	oat Car	cer		1 🗆 Ye	s 2 🗆 No 3 🗆 F	Probably 4 X Unknown
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Amend 20(date)6/27/06, per FD,6/27/06, drw 06-04217 Please Type or Print in Black Indelible Ink Amy Elickson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day June 18, 2006 **Medical Examiner** 0217 hrs Elizabeth Amy Ellickson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Baltimore 5. Social Security Number If Under 1 Year If Under 24Hrs. 6 Sex **Funeral** Age (In vrs. last birthday) 8. Date of Birth (MM/DD/YYYY) Birthplace (State or Months Days Hours Director 230-35-7795 Country Virginia M 2 X F Dec. 30,1969 36 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 X No 28a-f shov MD Calvert Huntingtown hours after death with the Maryland Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country' 4311 Estate Drive 20639 U.S.A. items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces' White etc. 1 Never Married 2 X Married Yes 2 X No Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify Specify. white ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 | tem 27 is marked other than traumatic event, the Medical Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 12 graphic artist printing and Mental Hygiene 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be John Charles Russo Susan Hudspeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and M Important: If item 27 is m injury or other traumatic e Austin Ellickson, husband 4311 Estate Dr., Huntingtown, 20639 MD20a. Method of Disposition 20b Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 27 1 Burial 2 X Cremation 3 Metropolitan Crematory 06-21-2006 Alexandria, VA Donation 5 Other Specify 2 Sunature of Funeral Service Livensee Rausch Funeral Home, P.A. Ovince Mt. Harmony Lane 22. Name and Address of Facility Part I/En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Complications of morbid obesity Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and item#1,23a,27,perME,g857,7/13/06 II UNPENDED AMENDED Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No After this certificate **✓** Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Hospital: 1 / Inpatient Other₄ DOA ER/Outpatient 3 Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28c. Injury at Work? 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of Injury 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No Director: I in by the f 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) within 24 hours a To the Funeral I Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started **Medical** 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day Year) O.C.M.E June 19, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 31. Date filed (Month) istrar's Signature

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			For State Registrar		State of N	/larylan		artment of				giene leg. No.	006	207	82
	Physicia		1. Decedent's Nam Edward	e (First, Middle, Las Frank	t)					i	2. Date of Dea June 18		Year	3. Time of [12:15	Death \mathbf{P}^{M}
	/Medic Examin		4a. Facility Name (If not institution, give	street and numbe	r)		4b. City, Town	, or Location	on of Death		4c. Cou	nty of Death	1	
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	Funeral Director		5. Social Security t 208 05 5	103	9X 7.7 ②M 2□F	Age (In yrs. I 89	ast birthday) Yrs.	If Under 1 Ye Months Da		der 24 Hrs. s Min.	8. Date of Birth (Month, Day 6/1/19]	, Year)	9. Birth	place (State or ntry) PA	
	and w	}	Usual Residence of 10a. State	10b. County		10c. City	r, Town or Lo	cation						10d. Inside City	y Limits
	Many -f sho	tor	MD	Howard		F	Ianovei	2						1 ☐ Yes	2 / No
	n 288	irec	10e. Street and Nu	mber	_			10f. Zip Cod	θ			10g. Citizen	of What Cou	ntry?	
	23a c	Funeral Director	6053 F	orey Rd.				21	076			US	SA		
	after death w or items 23a miner must L	nue	11. Marital Status		12. Was Deceder Armed Force 1 \(\text{Yes} \)	nt Ever in U.: s?	S. 13. Y	Was Decedent of Yes, specify C	of Hispanic uban, Mexi	Origin? (Spo can, Puerto	ecify Yes or No- Rican, etc.)	14. F	lace - Americ lack, White,		
38	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanthar must be rediffed at	by Fi	1 ☐ Never Man Widowed	ied 2□ Married 4□Divorced	1 ☐ Yes 25 If Yes, Give Year or Dates			1 □ Yes 2 🛣	No Spec	ify:		Spe	city: Whi	te	
21215-0036	72 hou	Completed	(Sne	15. Decedent's Ed			16a. Deced	tent's Usual Oc kind of work do	cupation	ost of work	ina	16b. Kind of	Business/In	dustry	
21:	ithin 7	npie	Elementary/Sec		College (1-4o	r 5+)	life.	DO NOT use re	rired)	rost or work	,,,g				
121	e filed within al Hygiene. I other than " vant, the Me		9	(First, Middle, Last)			Sales	Repres			(First, Middle,	Print			
Maryland	ould be fi Mental H arked ot atic evar	o Be		dward Fra	nk					by Cor		ivialdell Sull	iairio)		
Z.	2 should be and Mental is marked raumatic ev	T _o		ame/Relationship (7			19b. Mailir	ng Address (Str			al Route Numbe	r, City or Tov	vn, State, Zip	Code)	
	is 1 and 2 of Health ar item 27 is othar trac		Edward H	rank/Son			6053	3 Flore	y Rd.	Hanc	ver, MD	2107	76		
Baltimore,	iges 1 and of He		20a. Method of Dis	position Cremation 3	Aemoval from Sta	te Cé	emetery, cren	sition (Name of natory or other	olace)	1		20c. Locatio			
Ħ	permit. Pa Departmen Important: any injury once.			5 ☐ Other (Specify uneral Service Licen							2006 C				
Ba	permit. Pages. Department of h Important: If ite any injury or of		> 7/ev	mi Li Ro	de	M014					cy H. Wi k. Elli				
	Physician /Medical		23a. Part 1. Enter shock, or her Immediate Cause disease or conditi resulting in death)	on	ATHE)	line.	LEROT		9		VASCLE		Dice	Approximate Interval Betw Onset and De PSE	reen
	Examiner		Constant list of	andisia a	b	23 & CO113040	aerice orj.								
	ed isit	Examiner	Sequentially list or if any, leading to in cause. Enter Und Cause (Disease or	eriying	Due to (or a	as a consequ	uence of):							-	
Ć,	be executed siclan and burial-transit	Exan	that initiated event resulting in death)	s	C. Due to (or a	as a consequ	uence of):								
8760,	hysicia			(d										
9	entifica iling ph	Med	IF FEMALE:		02a If uga cutoon	an of process	201								
). Box	ie death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Medical	23b. Was deceder in the past 12 1 \sum Yes 2	! months?	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregna Other (specify					Date of delive Month		ear
P.O.	ac ==		9 Unknow	ficant conditions of	ontributing to death	but not resu	ulting in the u	ndertying cause	given in Pa	urt 1.	23e. Did to	bacco use co	ontribute to t	he cause of de	ath?
Vital Records,	w requires that s been signed t should be deta	ed by	, D	NTIA							1 □ Y	es 2□No	3 □ Prob	oably 4 📆 r	nknown
eco	2 2 2	Completed									24a. Was a			ppsy findings av	
<u> </u>	Th ate pag	Con									performula 1 🗆 Yes	med? 2[∑ No	death?	2□ No	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case refe examiner?	_	Hospital:						(Check only or				
of	S S D	. To	1 Yes 2		1 ☐ Inpa		ER/Outpatien 28b. Time of	1 JU DON			me 5 Reside			(y)	
on	Attanding Ph r death. ector: Atter th by the funeral	ition	1 ZNatural 2 ☐ Accident	5 Pending investigation	(Month, I	Day Year)	Injury		njuryat Vork? ∐Yes 2			,,			
Division	I or Attandil after death. Director: A I in by the fu	Certification:	3 Suicide	6 Could not be determined	288. Place of	Injury - At ho etc. (Specify	me, farm, str	eet, factory, offi	се		28f. Location (S City or Tow	treet and Nui n, State)	mber or Rura	al Route Numb	er,
	Hospital of the hours at Euneral D		29a. Certifier	152 Cortifying Ph	ysician: To the be	et of my know	wledge death	occurred at the	timo data	and place	and due to the c	auso(s) and	mannor as s	tatod	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	(Check only one)	2 ☐ Medical Exem	niner: On the basis and manner	of examinat	tion and/or in	estigation, in m	y opinion, o	death occurr	ed at the time, d	ause(s) and late and plac	e, and due to	tated. the cause(s)	
	To the within 2 To the complei	Me	29b. Signature and	title of certifier	. /	. 1		~	ense numbe		2	9d. Date sign	ned (Month,	Day, Year)	
			Ma	suell	n Xa	ll	an		2819			6/1	9/06		
906	-		30. Name and add	ress of person who	KHAN	, 72	23a) (Type,	PORK.	HE	ICPH	is Au	EIR	BALD	MD H.	208
	Sta Registr		31. Date filed (Mo.	JUN 2 0	2006 32. Red	strar's Signal	ture	berte							

			For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H tificate of		-	giene Reg. No. 20	06 20783
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath Day	3. Time of Death
	/Medic		Barbara Jean Ful	ton				June	16 20	06 911 PM
	Examir	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of I	Death	4c. County	
			Washington Count	v Hospita	1	Ha	gersta	SW7	Ma	
	Funeral		Washington Count 5. Social Security Number 6. Se	x 110.5 17. Age □ M 2 12 F		If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Birt (Month, Da NOV 30	h y, Year)	Birthplace (State or Foreign Country)
	Director		215-42-2755		63 Yrs.			Nov 30	1942	Maryland
	pur *		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or Lo	cation				10d. Inside City Limits
	sho	٦	Maryland Washir	nation	•	onsboro				1 ☐ Yes 2X No
	28a-1	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	
	with a or	ត់		1 21		101. 2ip 000e	21712			·
	s 23	Funerai	9004 Old Nationa	AL PIKE 12. Was Decedent 8	Ever in II S 12 1	Mas Decedest of h	21713	2 (Specify Vec or No		.S.A.
	iten de	Ë	11. Marital Status 1 ☐ Never Married 200 Married	Armed Forces?	10.3.	f Yes, specify Cub	an, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	Black	k, White, etc.
36	l', or	by	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2XINo	Specify:		Specify:	White
Ö	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Exambler must be notified at		15. Decedent's Edu		16a. Dece	dent's Usual Occur	pation		16b. Kind of Bu	siness/Industry
15	in 72	piet	(Specify only highest grad	le completed)	(Give	kind of work done DO NOT use retire	during most o	of working		,
212	within liene r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-		icer			Petrole	um Company
D	illed Hygi other	BeC	17. Father's Name (First, Middle, Last)	7-			18. Mother's	Name (First, Middle,		
<u>a</u> n	ld benta	ToB	Malcolm E. Shaw				Mami	ie A. Shirl	k Shaw	
Maryland 21215-0036	2 should be f and Mental I ie marked of eumatic eve	-	19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailir	ng Address (Street	and Number	or Rural Route Numbe	r, City or Town,	State, Zip Code)
	s 1 end 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show then treumatic event, it is Medical Examinar must be collised at		Adna B Eulton	(husband)	9004	tell bio	ional I	Pika Boonsl	oro Mar	yland 21713
ē,	item 27		Adna B. Fulton 20a. Method of Disposition	•	20b. Place of Dispo	sition (Name of natory or other pla	1	Date	20c. Location -	City or Town, State
e E	0 0 = 2		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Rest Have			-20-2006	Hagers	town Maryland
Baltimore,	- 문란를		21. Signature of Funeral Service Licens					Douglas A	Fierv	Funeral Home
ñ	Depa impo any ir		Dunala A	1 Trini						Maryland 21742
			23a. Part1. Enter the disease, or comp	lications that caused	the death. De set set					Approximate
	Dhusisian		shock, or hear failure. List only o	ne cause on each in	0/10/	RDISM	25- 1	70000		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. The last	a consequence of):	DKKM	1 0	ANCER		STOTAL
	Examiner			200 10 (01 40 1	2 00/130440/100 01).					
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):					
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events							
Ć,	execting an an ial-tr	Еха	resulting in death) Last	Due to (or as a	consequence of):					
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		(d						
9	g ph)	Physician/Medical								
Вох	death certifica attending ph d for use as th	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		1c:			23d. Date	of delivery
	death a atte	cia	in the past 12 months?	1 Live birth : 4 Pregnant at	time of death 5	Ectopic pregnancy Other (specify)	у		Mon	th Day Year
P.O.	that the de led by the a detached f	hys	9 □ Unknown	9Ll Unknown	-					
	es tha igned be det	by P	Part II. Other significant conditions co	ntributing to death bu	at not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
Records,	quire in sig uld b	ed t	BILLARY ONS	TRUCKO				1 D Y	es 2 No	3 ☐ Probably 4 ☐Unknown
00	w requir s been si should	Completed	URINGARY TE	set B	SATKLIET	inal		24a. Was	an 24b. W	/ere autopsy findings available
Re	The law sete has page 2:	E	Mar Will (ng 1/= Ci vii	U. V		autop perfor	med2 d	rior to completion of cause of eath?
of Vital		0	25. Was case referred to medical				26 Place of	1 ☐ Yes f Death (Check only o	0	☐ Yes 2☐ No
>	ysicit is cert direct	ToB	examiner?	Hospital: Inpatier	nt 2□ER/Outpatien	t 3 DOA Ott	or.	ing Home 5 Resid		r (Spacific)
þ	arthi eral		27. Manner of Death	28a. Date of Injur	y 28b. Time of				ow injury occurre	
ion	nding F th. : After e funer	tio	Natural 5 Pending investigation	(Month, Day	Year) Injury		rk? Yes 2∐No	,		
Division	or Attending Physician: after death. Director: After this certific in by the funeral director, i	Hice	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ry - At home, farm, str	eet, factory, office				r or Rural Route Number,
Ö	2 2 2 2	Certification;	4 Hornicide	building, etc	. (Зреспу)			City or Tow	m, State)	
,- W	spit hours inera y fille		29a. Certifier Certifying Phy	sician: To the best of	f my knowledge, death	occurred at the time	me, date and p	place, and due to the	ause(s) and mar	nner as stated.
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Exami	iner: On the basis of and manner sta	examination and/or in-	estigation, in my o	ppinion, death	occurred at the time, o	date and place, a	nd due to the cause(s)
	To the To the COMP	ž	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	(Month, Day, Year)
				n	110	040	622		SUN517	2001
			30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Type,	Print)				•
251	1-25		BRNESS WEDER	WIN)-1	np 192	36 Mb	Apoulu	18NOR	HAREK	round
	Sta	ite	31. Date filed (Month, Day, Year)		r's Signature	,			· · · · · · · · · · · · · · · · · · ·	
	Registr	rar	JUN 20 20	006 Augus	~ B. A.	1.11				

Physicia	ın	Decedent's Name (First, Middle, Last) Rachel Mae	Gormer		2. Date of Death Month Jun 28, 2	Day Year	3. Time of Death 1:30 am
/Medica Examine		4a. Facility Name (If not institution, give street and number) Cumberland Nursing Center		4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director			yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Pay,) Jun 17,	O Diah	place (State or Foreig
show a st		Usual Residence of Decedent 10a. State 10b. County 10c MD Allegany	c. City, Town or Loc	cation Derland			10d. Inside City Limits
ai', or itams 23a or 28a-f show Exacting the notified at	by Funeral Director	10e. Street and Number	Odini	10f. Zip Code	100	g. Citizen of What Cou	1 □ ¥es 2 □ No ntry?
ms 23a Frount	neral	512 Winifred Road 11. Marital Status 12. Was Decedent Ever	in U.S. 13. V	21502 Vas Decedent of Hispanic Origin? (Springer, Specify Cuban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Ameri	
one. than "natural", or itams 23a or 28a-f show he Medical Exactions count be collified at	d by Fur	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give Year or Dates:	1	☐ Yes 2 No Specify:		Specify: white	te
piene. r than "natural", the Medical Ex	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occupation kind of work done during most of work! DO NOT use retired)	ing 16	6b. Kind of Business/Ir	dustry
		Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)	homen		O' o (First, Middle, Ma	wn home	
and Mental H is marked of raumatic evar	To Be	Joseph Ryan			yan	alderi Surname)	
事な も		19a. Informant's Name/Relationship (Type, Print) James Gormer Jr. son	19b. Mailin 536	g Address (<i>Street and Number or Rura</i> N. Mechanic Street	al Route Number, C Cumbe		MD 21502
ent of Hea nt: If itam ry or othe		1 7 C 1 1 1 1 7 C 1 1 1 1 1 1 1 1 1 1 1	ob. Place of Dispos cemetery, crem Rocky Gap	natory or other place)		oc. Location - City or T	own, State
Department of I important: If its any injury or of once.		21. Signature of Furreral Service Licensee	V 22	Scarpelli Funeral Ho			
xaminer	Iner	Sequentially list conditions, Tary I acre to the mediate cause. Enter Underlying Cause (Disease or injury	nacquanna of):				
ysician and e burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	nsequence of):				
y the attending physician and ached for use as the burial-tran	ca	triat initiated events	egnancy Fetal death 3 🗆	Ectopic pregnancy Other (specify)		23d. Date of deliv- Month	ery Day Year
signed by the attending physician and Id be detached for use as the burial-tran	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant at time 9 Unknown Part II. Other significant conditions contributing to death but not	egnancy Fetal death 3 of death 5 t resulting in the un	Other (specify)	U.S.	Month cco use contribute to t	Day Year
ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	egnancy Fetal death 3 □ of death 5 □ t resulting in the un	Other (specify)	24a. Was an autopsy performe	Month cco use contribute to t 2 \(\text{No} \) 3 \(\text{Prot} \) 24b. Were autoprior to coded?	Day Year
n. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran	To Be Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not HRONIC BSTRUCT VI	egnancy Fetal death 3 G of death 5 G t resulting in the un	26. Place of Death 28c. Injury at Work?	24a. Was an autopsy performe 1 Yes 22 (Check only one)	Month cco use contribute to t 2 No 3 Prot prior to co death? 1 Yes Ce 6 Other (Special	Day Year the cause of death? ably 4 Dunknown psy findings available mpletion of cause of 2 No
ufter death. Diractor: After this certificate has been signed by the attending phy. in by the funeral director, page 2 should be detached for use as the	ertification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	egnancy Fetal death 3 of death 5 t resulting in the un Z	Other (specify) Iderlying cause given in Part I. 26. Place of Death 3 DOA Other: 4 Nursing Hor 28c. Injury at Work? M 1 Yes 2 No	24a. Was an autopsy performe 1 Yes 22 a. (Check only one) me 5 Residence 28d. Describe how	Month 2 No 3 Prot 24b. Were auto prior to co death? 1 Yes 1 Yes 1 injury occurred	Day Year the cause of death? sably 4 Dunknown psy findings available impletion of cause of 2 No
ufter death. Diractor: After this certificate has been signed by the attending phy. in by the funeral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	egnancy Fetal death 3 of death 5 of death 6	other (specify) Iderlying cause given in Part I. 26. Place of Death 26. Place of Death 27. Other: 4 Nursing Hor 28c. Injury at Work? M 1 Yes 2 No set, factory, office	24a. Was an autopsy performe 1 Yes 2 2 a. (Check only one) me 5 Residence 28d. Describe how 28f. Location (Stree City or Town, and due to the cau.	Month cco use contribute to t 2 No 3 Prot 24b. Were auto prior to co death? 1 Yes ce 6 Other (Special injury occurred et and Number or Rura State)	Day Year the cause of death? ably 4 Dunknown psy findings available mpletion of cause of 2 No W. Route Number,
within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transcending the completely filled in by the funeral director, page 2 should be detached for use as the burial-transcending.	Medical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	egnancy Fetal death 3 of death 5 of death 5 of death 5 of death 5 of death 5 of death 5 of death 5 of death 5 of death 5 of death 5 of death 5 of death 5 of death 5 of death 6	other (specify) Iderlying cause given in Part I. 26. Place of Death 27. Other: 4 Nursing Hor 28c. Injury at Work? M 1 Yes 2 No eet, factory, office 29c. License number 29c. License number 29c. License number	24a. Was an autopsy performe 1 Yes 22 a. (Check only one) me 5 Residence 28d. Describe how 28f. Location (Strectly or Town, and due to the caused at the time, date	Month cco use contribute to t 2 No 3 Prot 24b. Were auto prior to co death? 1 Yes ce 6 Other (Special injury occurred et and Number or Rura State)	Day Year the cause of death? pably 4 □Unknown psy findings available impletion of cause of 2 ☑ No 1/2 ☑ No 1/2 ☐ No 1/2

ORIGINAL

			For State	State	of Maryla	nd / Depa	artmer	nt of H	lealth a Death	and M			201	16	2078	5
			Registrar Decedent's Name (First, Middle,	Last)			rinca	011	504111		2. Date of De	Reg. No. ath			3. Time of Death	_
	nysicia		Mercedes A Cod	lorr AT	7.4 Mana	J		0 - 1 -	3.6	,	Month	Day			10 00 M	
	Medic kamin		Mercedes A. Good 4a. Facility Name (If not institution,	give street and	number)	des Ant	4b. City	. Town, or	Location of	IdCZa f Death	June		County of D	06. Death	10:00A	
	· Carrini	ζ.	Shady Grove Adv	entist	Hospita	1	Roc	kvi1	16			M	ontgor	0.01077		
Fur	neral			5. Sex	7. Age (In yrs	s. last birthday)		r 1 Year		24 Hrs. Min.	8. Date of Birt (Month, Da	h	9.	Birthpia Countr	ce (State or Foreign	7
Dire	ector		579-90-5302	1 □ M 2 🙀 I	104	Yrs.	WOTTE	Days	riours		Sep. 8)1 E			_
and	24	ł	Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or Lo	ocation							100	d. Inside City Limits	_
Manyl	a Dai	ō	Many land Mantage			n 1 .									1 ☐ Yes 2√∑ No	
the the	notif	Director	Maryland Montgon 10e. Street and Number	ery		Rockvi		p Code				10g. Citi:	zen of Wha	t Countr	y?	
h with	12		715 Harrington	Pond				2085	2				USA			
deat	E DE	Funeral	11. Marital Status	12. Was C	Decedent Ever in 1 1 Forces?	U.S. 13.	Was Dece	dent of Hi		gin? (Spe	cify Yes or No-		14. Race - A Black, V			_
after of Its	L.		1 Never Married 2 Marrie		es 2 ⊠ No		1 € Yes	•	Specify:	, 1 00101	rican, etc./		Specify:	vnite, et	C.	
Sours	Exe	d by	3 ☑ Widowed 4 □ Divorced	Yeard	or Dates:				Salv	vado	ran		W	<u>hite</u>		
72 1	100	Completed	15. Decedent's (Specify only highest	Education grade complete	e <i>d)</i>	16a. Dece	dent's Usu kind of w DO NOT i	ork done o	durina most	of worki	ng	16b. Kir	nd of Busine	ess/Indu	stry	
withir Bane.	Na M	μď	Elementary/Secondary (0-12)	Colleg	re (1-4or 5+)	Homem		130 /0///60	,			0	77			
III.Q. Z. I.Z. I.J. OUSSO. De filed within 72 hours after death with the Maryland Hyglene. d other than "natural" or ferms 23a or 28a-f show	event, the Medical Examinar must be notified at		17. Father's Name (First, Middle, L	ast)		Homen	arei		18. Mother	r's Name	(First, Middle,		Home			_
ld be lental	lo e v	То Ве	Jesus Mendoz	a					T 1 .	.	Codorz					
2 should be filed within and Mental Hygiene.	Tag.	-	19a. Informant's Name/Relationsh			19b. Maili	ng Addres	s (Street a			Godoy I Route Numbe	r, City or	Town, Sta	te, Zip C	ode)	
and 2 and 2 ealth a	any injury or other traumatic a once.		Rose Gutierrez	Daug	hter	9146	Turt	le D	ove La	ane	Gaithe	rshu	ro. M	TD 2	00879	
es 1 g	g ,		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	2 Demoval fr	20b.	Place of Dispo cemetery, cre tropol:	osition /wa	me or		D	ate	20c. Lo	cation - City	or Tow	n, State	
Pages ment of the	\$		4 Donation 5 Other (Sp.		Me	- C	remat	Orv	. Ta	un.1	7,2006	Alex	andri	a Vi	rainia	
permit. Departr	i i		21. Signature of Funeral Service L	censee	1	F.	2. Name a	nd Addres	s of Facility	ine	Funeral	Нот	o In	^	· · · · · · · · · · · · · · · · · · ·	
407	# SI		Ju x	Scere	0	اد	JU UII	iver	sity i	RTAG	.,W.,SI	Lver	Spri	ng,N	D 20901	_
			23a. Part1. Enter the disease, of o shock, or hear failure. List of	omplications the	at caused the dea on each line.	ath. Do not en	ter the mo	de of dyin	g, such as o	cardiac o	r respiratory ar	rest,		Ir	pproximate nterval Between	
Physi			Immediate Cause (Final disease or condition	_ a	RESPIR	ATORY	FA	ILU	RE						Onset and Death	2
/Med Exam			resulting in death)	Due	to (or as a conse		UF	2000	Pall	000					1	
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after Direction	d in	Certification:	4 Homicide determin	bu	uilding, etc. (Spec	cify)					City or Tow	m, State)				
bount bount	y fille		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To	the best of my kr	nowledge, deat	h occurred	at the tim	e, date and	place, a	and due to the o	ause(s)	and manne	r as state	ed.	-
UNISION OF VICE THE COLORS, F.C. BOX 007 007, With the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours affect death.	plete	Medical	one)	and m	e basis of examinanner stated.	ation and/or in				n occurre	at the time, o	ate and	piace, and	aue to th	ie cause(s)	
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			30. Name and address of person w		_											
. 15 4	-04		31. Date filed (Month, Day, Year)	NIPO	KARN Registrar's Sign	M.D.	9901	l_Med	ical	Cent	er Driv	re F	lockvi	11e	MD 20850	
R	Sta egistr		JUN 19	2006	e Luce A	nature	de									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Vernon I. Gilmore 2006 /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner Walters ForesTville Georg France If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number - Funeral Days 1∑M 2□F 76 226-30-9774 Director 6/3/1930 Virginia Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23a or 28a-f show the Mudical Examinar must be notified at Maryland Prince George 1 ☐ Yes 2 ☐ No Forestville Direct 10e. Street and Number 10g. Citizen of What Country? 3237 Walters Lane #1 20747 USA 12. Was Decedent Ever in U.S.
Amed Forces Retired
1 (XYes 2 | Retired
If Yes, Give
Year or Dates: 1974 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Bi-Racial þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Tech Sergeant US Air Force 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filment of Health and Mental Hisnt: If item 27 is marked oti Corrine Roberts William R. Gilmore, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Takako Gilmore/Ex-wife 2100 Brooks Dr. #603 Forestville, MD. 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Importent: If it any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arl. Nat. Cemetery 7/3/06 4 □Donation 5 □ Other (Specify) Arlington, VA. 22. Name and Address of Facility Geo. P. Kalas Funeral Home 21. Signature Funeral Service Licensee 6160 Oxon Hill Rd. Oxon Hill, Md. Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Arterioscleratic Hypertenine Heart Diseas **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit or Attending Physicism: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗆 No 1 Yes 2 No 1 Tes After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Dther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1- Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide within 24 hours a To the Funaral I 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Amedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Chave 3001 SIALVADOR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 9 2006 Registrar

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IX OTTIX		1- For State Registrar	•	cate of D		rivientari		g. No. 2	006 2078
Physici	an/	1. Decedent's Name (First, Middle,Last) Lemar Val	Gran	 nt			2. Date of Death Month June 10, 20	Day Year	3. Time of Death 2305 hrs
		4a. Facility Name (if not institution, give street and number)			•	Location of Death		4c. County of	
		701 Ethan Allen Avenue 5. Social Security Number 6. Sex 7. Age	(In yrs, last bi		Takoma Par If Under 1 Year	If Under 24Hrs	8 Date of Birth	Montgom	9 Birthplace (State or
Funeral Director		226-53-7434 1XM 2_F	20		Months Days				ForeigMaryland
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Towi	n or Location					10d. Inside City Limits
*	ō	VA. Fairfax	Vienr						1 X Yes 2 No
vith the Maryland s 23a or 28a-f show s s notified at once.	Director	10e. Street and Number 248 Cedar Lane #150		1	22180		10	g Citizen of Wha	t Country?
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fter dea		3 Widowed 4 Divorced If Yes, Give Year	No	1 Y	es 2 X No	specify:		Specify:	Black
hours a natura Examir	ed by	15. Decedent's Education (Specify only highest grade com				on (Give kind of DO NOT use ret		16b. Kind of Busi	ness/Industry
036 Ithin 72 hours ne r than "natur fedical Exam	Completed	Elementary/Secondary (0-12) College (1-4 or 5		Waste	Manag	ement		Recyc	ling Co.
Ore, MD 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho ther traumatic event, the Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, Last) Val Grant				Marjo	e (First, Middle, M rie Lav	rence	
and 2 should lealth and M tem 27 is m traumatic	То	19a. Informant's Name/Relationship (Type, Print) Val Grant/Father	1						State, Zip Code) , Md. 20853
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Baltimore, I permit. Pages 1 and Department of Healinportant: If item injury or other tra		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Gat		Heaven		17/06		Spring, MD.
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Physician /Medical Examiner		23a. Part I. Inter the disease, or complications that caused failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunsho		not enter the	mode of dying,	such as cardiac	or respiratory arre	st, shock, or hear	t Approximate Interval Between Onset and Death
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Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown	time of death	5 Other	r (Specify)				
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Division of Vital Records, tal or Attending Physician: The law requires are death as the return After this certificate has been sited in by the funeral director, page 2 should b	n: To	27. Manner of Death 28a. Date of Inju	n/ 28h	b. Time of Inju	ury 28c. Injur	y at Work?		ow injury occurred	·
ivisior or Attend after death Director:	catic	2 Accident Investigation Jun 10, 2006	22	57 hrs		res 2 ✓ No uilding etc	28f. Location (S	treet and Number	or Rural Route Number, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical (29a. Certifier (Check only 1 ☐ Certifying Physician: To the best of my one) 2 ✓ Medical Examiner: On the basis of examiner and manner stated.							
F 3 F 8	Me.	29b. Signature and title of certifier			29c, Licenso			29d. Date signed June 11, 20	d (Month, Day, Year) 06
		30. Name and address of person who completed cause and	eath (Item 23a	,					
		Theodore King MD. Assistant Medical E	xaminer		n Street, Ba	ltimore, MD 2	21201		
S Regis	itate strar	11 1 1 6 7111 1 Edward		A PAGE	MES				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 23h. 29d per doc 9857 7-3-06 vt. State of Maryland 7 Department of Health and Mental Hygiene 2000 20788 Certificate of Death Reg. No.

1 - For State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

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Registrar

JUI 0 3 2006

		-	State of Maryland / D State of Maryland / D Registrer		rtment of tificate o				giene Reg. No.	2006	20	789
	Physicia		1. Decedent's Name (First, Middle, Last) Lois Jacqueline Hockman					2. Date of De Month June	ath 2 ^{Day}	2ઁ00€	3. Time of 9:25	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 328 Roberts Way		4b. City, Town		of Death			County of Deat		
	Funeral Director		5. Social Security Number 220-30-9820 6. Sex 1 □ M 2区 F 77 Y Usual Residence of Decedent	hday) (rs.	If Under 1 Yes Months Day		Min.	8. Date of Bir (Month, Da 2/11/19	th y <i>Year)</i> 929	9. Birt Co Penr	hplace (State o untry) 1sylvan	ia ia
	Maryland -f show lied at	tor	10a. State								10d. Inside Ci 1 X Yes	
	with the a or 28a be notil	Direc	10e. Street and Number 328 Roberts Way		10f. Zip Code				_	zen of What Co	untry?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or iteme 23a or 28a-f show any rightry or other treumatic event, the Mountal Examiner must be notified at anone.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 KWidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	l If	Vas Decedent c Yes, specify C	f Hispanic O uban, Mexica	n, Puerto	ecify Yes or No Rican, etc.)		14. Race - Ame Black, Whit Specify: Whit	e, etc.	
21215-0036	within 72 hou ene. than "nature	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	(Give F life. D	ent's Usual Occ kind of work do OO NOT use ret	ne durina mo	st of worki	ng	16b. Kii	nd of Business/		
nd 2	be filed tal Hygie d other event, II	Be	17. Father's Name (First, Middle, Last)	se				(First, Middle		Sing		
Maryland	should and Men a marke umatic	၉	1.1.1		_	et and Numb		I Route Numb	-	Town, State, 2	?ip Code)	
	1 and 2 Health a em 27 lo		20a Method of Disposition 20b. Place of	Dispos	Kansala sition (Name of			polis,		21401 cation - City or	Town, State	
Baltimore,	Pages ment of ant: If it		1 M Burial 2 Cramation 3 Leamoval from State :	r N	natory or other p Mem. Gdr	ns.	6/30/	_		Air, Ma	aryland	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee Curston Amy Ung Les blue		rarring- Aberdeer					A. 9		
The second	Fnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	uch			1	er respiratory a	rrest,		Approximat Interval Bet Onset and I	ween
8760,		ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence or c. Due to (or as a consequence or c.									
P.O. Box 68	ath certifi ttending or use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes Y No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnal				2	23d. Date of del Month		Year
	quires that the de n signed by the a uld be detached t	by	Part II. Other significant conditions contributing to death but not resulting in	the un	nderlying cause	given in Part	I.		obacco u Yes 2[se contribute to		leath? Jnknown
I Records,	The ate h	Completed		-				24a. Was autor perfo		24b. Were au prior to death?	topsy findings completion of c	available ause of
Vital	ysicien: Th is certificate director, pag	o Be (25. Was case referred to medical examiner? 1 Yes 3 No Hospital: 1 Inpatient 2 ER/Out	nation	t 3 DOA	Other	e of Death	(Check only o		3 □Other (Spe	nife()	
Division of		\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident 28a. Date of Injury (Month, Day Year) In		28c. Ir			28d. Describe			ыу) -	
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, stre	eet, factory, offic	Ce Ce		28f. Location (City or To		d Number or Ru	<i>ral R</i> ou <i>te Nu</i> m	ber,
	he Hospi in 24 hour he Funer pletely fill	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, 2□ Medical Examiner: On the basis of examination and and manner stated.		estigation, in m	y opinion, de			date and	place, and due	to the cause(s)
)	To t with To t	Σ	29b. Signature and title of certifier Mashant Shukla, MD			o 4 809	0			e signed (Mont)	n, Day, Year)	
	10		30. Name and address of person who completed cause of death (Item 23a) (Prashant Shukka 15 S. Parke Street	1#	400 Ab	erdeer	M	iryland	210	0		
	Sta Registi		31. Date filed (Month, Day, Year) 32/ Registrar's Signature	A Par	ste s							

		•	For State Registrar	State of Maryland		artment of near		entai my	rgieni Reg. No	4000	20790
			1. Decedent's Name (First, Middle, La					2. Date of De Month	eath Da	av Year	3. Time of Death
	Physici /Medic		Stanley	Willis		Harris		June	14,	2006	10:00a ^M
,	Examin	er	4a. Facility Name (If not institution, giv			4b. City, Town, or Local Baltime			40	c. County of Death	
			210 N.Gilmor S 5. Social Security Number 6. S		ast hirthday)		Jnder 24 Hrs.	8. Date of Bi	rth	9 Birth	place (State or Foreign
	Funeral Director			M 2□F 43	Yrs.		ours Min.	8. Date of Bi (Month, D	6/19	962 Ba.	ltimore, MD
	land ow		10a. State 10b. County		, Town or Lo						10d. Inside City Limits
	Man,	ţo	MD	Ba	altim	ore					1 May Yes 2 No
	with the 3s or 28	I Direc	10e. Street and Number 210 N.Gilmor S	Street Apt.A		10f. Zip Code 21223			10g. C	itizen of What Cou USA	ntry?
200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23s or 28s-f show any injury or other traumatic event, it is Medical Examinar most be notified at another.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hispan If Yes, specify Cuban, Mo 1 ☐ Yes 2 🏋 No Sp	nic Origin? (Spe lexican, Puerto l pecify:	ecify Yes or N Rican, etc.)	0-	14. Race - Ameri Black, White, Specify:	
ה ה	72 ho natur	Completed	15. Decedent's E		16a. Dece	dent's Usual Occupation kind of work done during DO NOT use retired)	g most of worki	ng	16b. i	Kind of Business/Ir	ndustry
V	Athin ne.	ap du	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired) elt mechan			B	altimor	e Belting
7	Hygiel Hygiel Ther ti	ဒီ	1.2 Tather's Name (First, Middle, Last	1	De		Mother's Name	/First Middle			
ב ב	ontail h	Be c	Edward Shuffo				larion			, obmano,	
	shoulk nd Me mark mark	၉	19a. Informant's Name/Relationship (19b. Maili	ng Address (Street and N				or Town, State, Zij	p Code) ၁၁၁
Z Z	nd 2 :	l i	Teresa Harris/			N.Gilmor					
ກັ	Item 2		20a. Method of Disposition	20b. Pl		osition (Name of matory or other place)		ate		ocation - City or T	
	Page nent c		1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Themoval mon State		wn Cem.	6/17/	06	Ba	ltimore	- bM.≤
partimore,	permit. Departri Importa any inju		21. Signature of Funeral Service Lo	see ,	2: F	Name and Address of HILIP D. R	Facility	FUNE	ERAL	SERVIC	
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1	/Medical		resulting in death)	Due to (or as a consequ							
	Examiner		Sequentially list conditions,	b. Lung ca	uzer						2 William .
_	ed sit	Examiner	Sequentially list conditions, it any, leading 10 introducts cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (or as ¥ sonsaqu	liance ott:						
	and al-trar	xan	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):						
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000	tificate be executed g physicien and as the burial-translt	ledicai		_ v.					- 1		
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as, r.	requires that the death een signed by the atter hould be detached for u	5	Part II. Other significant conditions of headach to B	ontributing to death but not resu	ulting in the u	inderlying cause given in	Part I.		tobacco Yes 2		the cause of death?
ecords	v requ been shoul	Completed		1.1	. (24a. Was	s an	24h Were auto	opsy findings available
ě	6	E C	huma immi	enodebiciency vi	nia (HIV)		auto perf	psy ormed?	prior to co death?	empletion of cause of
	ificete or. pa	ပိ	25. Was case referred to medical			26	Place of Death	1 Yes		o 1 ☐ Yes	2□ No
	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 € No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatier	0				6 ☐Other (Special	fv)
10 00	ding Phy h. After thi funeral o	tion: T	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		2	28d. Describe			<i>"</i>
UNISION	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funarel Director: After this certificate ha completely filled in by the funeral director, page	Certification;	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	00 00 01 111 0 445		reet, factory, office	1	28f. Location City or To		nd Number or Run e)	al Route Number,
_	Hospitel	edical Co	(Check only 2 Medical Example 1997)	hydician: To the best of my know miner: On the basis of examinat	wledge: daat tion and/or in	h course at the films, divestigation, in my opinion	ata and place at n, death occurre	und dua to the ed at the time	czuse(s , date an	l) and manner as t id place, and due t	stated. o the cause(s)
	ithin 2 the implei	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License nun	mber		29d. Da	ate signed (Month,	Day, Year)
	F 3 F 8		1 Contra	Dayle no		D23				luve 16	
, ,	P	1	30. Name and address of person who		1 23a) (Tyne		4		~	140	,
			1 10 11 10 11	me, Creene boun	Cour-	er Ctr., 22	S. Cres	ne St	Box	leternero N	M 2120
	Sta	ate	31. Date filed (Month, Day, Year)	2006 32 Registrar's Signat	ture	artis					4
	Regist	rar	JUN I 3	LUUD JOHN A	10						

			1 - For State of Maryland / Departr	ment of Health and Me licate of Death		ene2006	20791
			Decedent's Name (First, Middle, Last)	2	2. Date of Death		3. Time of Death
П	Physicia /Medic		CHARLES HURT	J	Month TUNE 1	Day Year 2006	5:45A. ^M
	Examin		4a. Facility Name (If not institution, give street and number) 4b.	c. City, Town, or Location of Death		4c. County of Death	
				FORESTVILLE		PRINCE G	
	Funeral		10 M	Under 1 Year If Under 24 Hrs. a onths Days Hours Min.	B. Date of Birth (Month, Day, Y	(ear) 9. Birthp	place (State or Foreign
	Director		225-44-9147 71 Yrs. Usual Residence of Decedent		7 - 4-	1934BED	FORD, CO
	/land	Ì	10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	Man a-f eh	tor	MD PRINCE GEORGE'S CAPITOL	HEIGHTS			Yos 2□No
	th the	lrec	10e. Street and Number	Of. Zip Code	10g	. Citizen of What Cour	ntry?
	23a	Funeral Director	1919 NOVA AVE.,	20743	U	NITED ST	ATES .
	tems	nue	Armed Forces?	Decedent of Hispanic Origin? (Speci s, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	
36	rs afte	by F	1 □ Never Married 2X Married 1 □ Yes 2 □ No If Yes, Give 1 □ 3 □ Widowed 4 □ Divorced Year or Dates:	Yes 2 No Specify:		Specify: BL	ACK
Ş	thou stura	edt	15. Decedent's Education 16a. Decedent's	's Usual Occupation	16	b. Kind of Business/In	dustry
7	nin 72 in "na Medi	ple	(Specify only highest grade completed) (Give kind life. DO N	d of work done during most of working NOT use retired)	7		
2	ar the	Completed	7th	LABORER		ONSTRUCT:	ION
nd	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "neturel", or items 23a or 28a-f ehow event, the Medical Evantiest must be molitied at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (iden Sumame)	
<u>\</u>	should be filed within 72 hours after death with the Marylan and Mental Hyglene. In Marked other than "naturel", or flems 23a or 28a-f ehow marke ovent, the Medical Examination in a be indiffied at	70	WILLIAM R. HURT	LUDIE SP			
Maryland 21215-0036	S Se se S		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ac RACHEL HURT/WIFE 3001 B:	ddress (Street and Number or Rural RANCH AVE., #5	31 TEM	DT.F. HTT.T.S	20748
_	is 1 and 2 of Health itam 27 other tr		20a. Method of Disposition 20b. Place of Disposition	n (Name of Dat		c. Location - City or To	
Baltimore,	Pages nent of I ant: If its ary or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Donation 5 ☐ Other (Specify)	CEMETERY 6-15-	06	WASHINGTO	ON D C
票	permit. Pages Department of Important: If i any Injury or o		A A	ame and Address of Facility		WIIDHIINGI	20002
m	Deg		Maior Shoot Jally 142!	5 MARYLAND AVE	., N.E	. WASHING	GTON, D.C.
			23a. Part1. Enter the disease, or complications that caused the death. Definition of the shock, or heart failure. Usy only one cause on each line.	e mode of dying, such as cardiac or	respiratory arrest	t,	Approximate Interval Between
	Pnysician _I		Immediate Cause (Final disease or condition CANCER OF	PANCREAS			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
Н	LAdrinici	<u>.</u>	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):				
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8760,	ate be executed physician and the burial-transit	dlcal	d				
9	ntifica ng ph as th	Ved	IF FEMALE:		71		
Вох	eath certific attending pl	an/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ecto	opic pregnancy		23d. Date of delive Month	Day Year
0	the all	Physiclan/Me	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Oth 9 ☐ Unknown	her (specify)			Day Voc
<u>a</u>	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Ph	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?
Records,	uires signe	d by		, ,	1 ☐ Yes	2 No 3 Prob	ably 4 Munknown
S	w requir been si should	lete			24a. Was an	24b. Were auto	psy findings available
Re	he lav e has age 2	ompleted			autopsy performe	prior to co.	mpletion of cause of 2X No
Vital		e C	25. Was case referred to medical	26. Place of Death (No 1 ☐ Yes	201110
	Physician: this certific	To B	examiner? 1 Yes 2 XNo Hospital: 1 Inpatient 2 ER/Outpatient 3	3□ DOA Other: X Nursing Home	e 5 ☐ Residend	ce 6 □Other (Specif	y)
0	ding Phi h. After thi funeral	on:	27. Manner of Death 28a. Date of Injury 28b. Time of (Month, Day Year) 28b. Time of Injury	Work?	d. Describe how	injury occurred	
sio	Attending or death. actor: Atter by the funer	catl	2 Accident	M 1 Yes 2 No	6 h 1 (Char		
Division of	1 th 1	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office 28	City or Town, S	et and Number or Rura State)	ii Houte Number,
	spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ	curred at the time, date and place, an	d due to the caus	se(s) and manner as s	tated.
	To the Hospital or within 24 hours afte To the Funeral DII completely filled in	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.	gation, in my opinion, death occurred	at the time, date	and place, and due to	the cause(s)
	Within To the Comp	Σ	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month,	Day, Year)
•			(Ollming)	D51520		6-17-06	
	(2)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print	11 20747	Bahn	am Pishda	1
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	TU. OU 17/		112140	14
	Registr		30. Name and address of person who completed cause of death (flem 23) (Type, Print 1420 Maubow the Foretylle 131. Date filed (Month, Day, Year) JUN 1 9 2006 Leave The Toler of the Print 1999. Prin	,			

			For State Registrar	State of Ma	ryland		artment rtificate			and M		giene Reg. No.	2006	207	9 2
	Dhysisi		1. Decedent's Name (First, Middle	, Last)							2. Date of Dea	ath Day	Year	3. Time of Deat	h
	Physici /Medio		David Willis H								6	19	2006	12:30 H	M
	Examin	ner	4a. Facility Name (If not institution,	· ·					Location o	of Death			County of Death		
			Atlantic Gener 5. Social Security Number		(In yrs. lasi	t birthday)	Ber If Under 1		If Under a	24 Hrs.	8. Date of Birt		Worcest		eian
	Funeral Director		217-52-0303	1⊠M 2□F	56	Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Date 5/11/1	950	Col	place (State or Fore intry) MD	Jigiri
7			Usual Residence of Decedenl												
aNa	ehov M M	-	10a. State 10b. County		10c. City, T		calion							10d. Inside City Lim 1 Yes 2 □	
A M	28a-1	Director	MD Worce 10e. Street and Number	ster	Ber	lin	10f. Zip (20do				10a Citis	zen of Whal Cou		
death with the Maryland	lban.	급	109 W. Bucking	ham Pd			,	2181	1			-	SA	iiitiy !	
death	ms 2	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. \				gin? (Spe	cify Yes or No- Rican, etc.)		4. Race - Amer		
ā	or le	교	1 Never Married 2 ☑ Marri		0		f Yes, specif		n, Mexican Specify:	, Puerto I	Rican, etc.)	1	Black, White	, etc.	
215-0036	"natural", or Items 23a or 28a-f ehow solical Examinar must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			10 105 2.	AND IND	эреспу.				Specify: Wh:	ite	
ה ה ה	hatt	Completed	15. Decedent (Specify only highes	s Education t grade completed)	1	Give	den!'s Usual kind of work DO NOT use	Occupa	ition Juring most	of working	ng	16b. Kir	nd of Business/Ir	ndustry	
- 3	than a	m d	Elementary/Secondary (0-12)	College (1-4or 5-	+)		Build					Том	n Munic	inality	
N G	Hygi thar int, I	ပိ	17. Father's Name (First, Middle, L	<u>'</u>		Road	Daria		-		(First, Middle,			LPALLLY	
yland yland		To B	Willis Hudson						I	Norma	a Cropp	er			
_ ~	of Health and Ment Item 27 is marker r other traumatic		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street a					Town, State, Zi	p Code)	
, Mai	n 27 I		Sue Ann Hudson	(wife)									D 21811		
Saltimore,	portners of Health portent: If Item 27 by Injury or other to		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 □Removal from State	20b. Plac	e of Dispo etery, cren	sition (Name natory or oth	e of her place	9)	D	ate	20c. Lo	cation - City or T	own, State	
	ment ent:		4 ☐ Donation 5 ☐ Other (Sp	ecify)	Cape		open				2006		nkford,		
	Departing any injuries		21. Signature of Furnial Service L	Liceogee								_	uneral l	Home	
	10 = 6 0		23a. Part1. Errer the disease, or	somplications that caused	the death						erlin,		1811	Approximate	
P	hysician		shock, or heart failure. List of limmediate Cause (Final disease or condition	only one cause on each line	е.							1631,		Interval Between Onset and Death	
	Medical		resulting in death)	a. HCUTE Due to (or as a			TRAIL	75	INF	HEC	CON			EN ININI	
E	xaminer		Sequentially list canditions	b. ASCV	0								7	ON TEAKS	
pe	sit	Examiner	Sequentially list nunditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequer	ice of):									
6U,	and Il-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a	consequer	nce of):				-			_		_
		icalE											Ī		
od/	phy:	edic		0											
. BOX 68/	attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Tetopia ava					2	3d. Date of deliv	ery	
ָבָּ בַּ	e atte	lcla	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown			Ectopic pre Other (spe						Month	Day Year	
ے ق	by the steched	hys	9 ☐ Unknown												
£	igned be det	þ	Part II, Dther significant conditio		t not resultir	ng in the ur	nderlying ca	use give	n in Part I.					the cause of death?	
ecords,	been sig	eted	- JIABETES	MELLITUS								res 2L	JN0 3 PIO	bably 4 <u>Mu</u> nkno	wn
S S	has b	Completed									24a. Was autop		24b. Were auto	opsy findings availa empletion of cause of	ble of
	pag pag											2 No	1 Yes	2□ No	
VISION OF VITAL	this certificaral director, p	o Be	25. Was case referred to medicat examiner? 1 Yes 2 □ No	Hospital:	o3527.F.D	1/0		Othe			(Check only o		F1011 10		
5	or this eral d	 -	27. Manner of Death	1 ☐ Inpatier 28a. Date of Injury (Month, Day)		Bb. Time of	t 3 DOA	c. Injury Work	4 🗆 Nu		e 5 ☐ Hesid		Olher (Speci	fy)	
ם פון	ith. :: After e funera	to	1 Pending 2 Accident Investig	9	Year)	Injury	, M		:? /es 2 □ N	No					
	ter death. Irector: Ai n by the fu	HICE	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be ned 28e. Place of Inju- building, etc.	ry - At home	e, farm, str	eet, factory,	office		2	28f. Location (S City or Tow	Street and	Number or Rur	al Route Number,	
בֿ בֿ		Certification:		Building, etc.	. (Opecity)						Ony or 10th	ni, State)			
Hosnital	within 24 hours a To the Funeral C completely filled	edical	29a. Certifier 1 Certifyin (Check only 2 Medical E	g Physician: To the best of Examiner: On the basis of and manner stat	examination	edge, death and/or inv	occurred a vestigation, i	t the tim in my op	e, date and inion, deat	d place, a th occurre	and due to the ded at the time, d	cause(s) date and	and manner as s place, and due t	stated. o the cause(s)	
, d	vithin Fo the	₩ W	29b. Signature and title of certifier				29c.	License	number			29d. Date	signed (Month,	Day, Year)	
)	- ·- ·		Prothe 1	Helwatt)	m.s.			000	6241	,		6-	20-0K	, >	
			30. Name and address of person	who completed cause of de	eath (Item 23	За) (Туре,	Print)								
٤.	1 10		DOROTHY C.	HOLZWOR	TH, 1	V1. D.	20	35	NOUN	Sn	SHOUR	Hus	Mo	2/863	
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 0	32. Segistra	r's Signatur	A	and a								

State of Maryland / Department of Health and Mental Hygiene 2 115 Certificate of Death 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) ^{Day} 2006 **Physician** June 19, 3:12 A^{M} Dorothy Isabel Gettel Hamilton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (St. Country) | 1928 | Mary Land 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ ¥F 218-26-4726 77 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23a or 28a-f ehow the Medical Examiner; sust be notified at 1 ☐ Yes 2 ☐ No Director Maryland | Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21044 USA 5400 Vantage Point Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White ģ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) University Educator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finand Mental His marked of Robert Stanley Gettel Jennie Saul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health ar Illem 27 is P.O. Box 20223 Seattle, Washington 98102 Charles Hamilton/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ment of F tant: If Its 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) 06/20/06 Beltsville, Maryland Chesapeake Crematory 21. Signatura of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) metastatio **Physician** /Medical Due to (or as a consequence of): Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) and Il-transit resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician (page 2 should be detached for use as the burial cal Physician/Medi 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ō 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: il or Attanding F after death. Division 1 Natural 5 Pending investigation after death.
Director: After do in by the front 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 25205 June 19, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto, MA 7:20% Mr Charles St. 12 BMC 32. Resetrar's Signature 31. Date filed (Month, Day, Year) JUN 2 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For Stata Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year Physician William Hall, Sr. 2006 2:30p June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5702 SEMINOLE ST. BERWYN HIGHTS PRINCE GEORGES If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9-9-39 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1√2 M 2□ F 217-36-1633 66 Yrs. Director **DELAWARE** Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. stherthan "natural", or Iteme 23a or 28a-f ehow ent, the Micdical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Directo WICOMICO SALISBURY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 212 PRINCE ST. 21804 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 🏵 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify. Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION 8 Pages 1 and 2 should be filed w thrent of Health and Mental Hygier trant: If item 27 ie marked other ti jury or other treumatic event, TAXI DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EVERETT HALL SALLY PACKER ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KEITH HALL - SON 5702 SEMINOLE ST., BERWYN HIGHTS, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRINGHILL MEM.GDNS. permit. Page Department of Important: If eny injury or once. 6/16/06 HEBRON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BOUNDS FUNERAL HOME 705 EAST MAIN ST, SALISBURY 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC LUNG CANCER /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE LUNG DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2X No this certificate 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home ဥ 1 ☐ Yes 2 ☒ No 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 ☐ Pending 1 □ Yes 2 □ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) à 4 - Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28079 6-15-06 who completed cause of death (Item 230 (Type, Print)

JE DRIVE RET TOTAL BELTSVILLE, MD 20705 11700 BELTSVILLE DRIVE, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #19b per/fh 06-26-2006 entiticate of Death Reg. No.2 11 0 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** Lee Ford Harwood 14, 2006 7:45 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5941 Broad Run Rd. Jeilelbun

| Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth
| Days | Hours | Min. | June 4, 1914 Jefferson Frederick Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral ₩** 2 □ F Months 710-09-6735 92 Yrs PA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ₩0H@ ms 23a or 28e-f ehov 1 Yes 2 No **Funeral Director** MD Frederick Jefferson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 5941 Broad Run Rd. 21755 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status traumatic event, the Madical Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: 3 X Widowed 4 ☐ Divorced White natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) farmer farm owner 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Meniat Hy Importent: if Item 27 is marked othe eny lipity or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Lee C. Harwood Nell Newkirk 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Crampton (Daughter) Jefferson, MD 21755 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State
4 Conation 5 Other (Specify)
Signature of Themas Service Licenses Mt. Olivet Cemetery 6/17/06 Frederick, MD 22. Name and Address of Facility
Donald B. Thompson Funeral Home urt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and cause on each line. 21769 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) o rehrowasculir accident Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 4☐ Pregnant at time of death 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 20 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this After this funeral of 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time ol 28d. Describe how injury occurred Certification; Injury 5 🗌 Pending after death.

Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours after To the Funeral Dire To the Hospitei 🔁 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 009689 15/06 TUFFRE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREETICK MD 2170 AUSTIN PEULLE gistrar's Signature State 2006 Registrar

06-04090 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Albert Stanley Isaacs 1- For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Albert 1140 hrs Medical Examiner June 14, 2006 Stanley Isaacs 4b. City, Town, or Location of Death 1c. County of Death 4a Facility Name (if not institution, give street and number) 2921 North Leisure World Boulevard Silver Spring Montgomery 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director Country) 128-20-4795 77 12/4/1928 NY 1 X M 2 F Yrs Usual Residence of Decedent any 10c City, Town or Location 10d Inside City Limits 1 XYes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 2 its marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. MD Montgomery Silver Spring Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2921 North Leisure World Blvd #20. 20906 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 | Married 2 X No Yes White 3 XWidowed Divorced f Yes, Give Year 1 Yes 2 X No specify: 2 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 4+ Administrator New York City Gov't 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha Goldman Irving Isaacs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10813 Pebble Brooke Lane Potomac MD 20854 Susan L. Biro - Daughter 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 X Removal from State 6/16/06 | Vahalla NY Donation 5 Other Specify. <u>Sharon</u> Gardens 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852

Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

Applications of the Hood indivision complications because on each line Hood indivision complications because on each line Hood indivision complications because of the Hood indivision complications are supplied to the Hood indivision complications are supplied to the Hood indivision complication because of the Hood indivision complications are supplied to the Hood indivision complications are supplied to the Hood indivision complication and the Hood indivision complications are supplied to the Hood indivision complications are supplied to the Hood indivision complications are supplied to the Hood indivision complication and the Hood indivision complication complications are supplied to the Hood indivision complication and the Hood indivision complication complication complications are supplied to the Hood indivision complication compl Approximate Interval Physician Tailure. List only one cause on each line. Head injuries complicating hypertensive atherosclerotic ediate Cause (Final disease a Hypertensive Atherosclerotic Cardiovascular Disease Cardiovascular disease Between Onset and /Medical Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical item#23a,2/,28a-t,perML,g85/,//12/06 TT X AMENDED UNPENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has funeral director, page 2 sl nerformed? death? 1 🗸 Yes ✓ Yes 2 No No 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be Hospital: 1 Inpatient 2 Other₄ Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 V Yes ဂ္ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred subject fell while taking blood Certification: Yes 2 y No within 24 hours after death.

To the Funeral Director:
completely filled in by the f Pending June 14, 2006 Fnd 11:00 am thinning medication 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2921 N Leisure World Llvd. Silver Spring, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined (Specify) House 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifier O.C.M.E. June 15, 2006

State

Registrar

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

2006

Ana Rubio MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registrar's Signature

			1 - For State Registrar	State of M	Marylan	,	artment tificate					Reg. No.	20	96	2079
	Physici /Medio		1. Decedent's Name (First, Middle, L ELLEN CHARLOTTE								2. Date of De. Month	ath Day	200	ır	Time of Death
	Examir		4a. Facility Name (If not institution, g WM H5-BRaddo				Cun	NBE	Location of	ano		A	County of Di LLEG		Y
	Funeral Director		217-28-2311	Sex 1□M 2□F	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da JAN 14	th y, Year) 192		Birthplace Country) ARYLA	(State or Foreign
	Aaryland	ō	Usual Residence of Decedent 10a. State 10b. County MD ALLEGA	NTV		y, Town or Lo									nside City Limits
	with the ha or 28a-	Direct	10e. Street and Number 99 FROST VILLAGE		FF	COSTBUR	10f. Zip					-	zen of What		Δ
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show says Injury or other traumatic event, the Medical Exerting russ) be notified at ADE.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decede	\$? \$ No	'		lent of His	spanic Origin, Mexican	gin? (Spec i, Puerto R	cify Yes or No Rican, etc.)		14. Race - A Black, W Specify:	merican In	
21215-0036	1 within 72 hou liene. r than "natura the Medical E	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12		r 5+)	16a. Deced (Give life. I	kind of wor DO NOT us	k done d	urina most	t of workin	g		nd of Busine	ss/Industry	y
Maryland 2	uld be filed Aental Hygi irked other itic event, I	To Be C	17. Father's Name (First, Middle, Las CHARLES TAYLOR	st)		,					(First, Middle,	Maiden TAYL			
	and 2 sho saith and h a 27 is ma ar trauma		19a. Informant's Name/Relationship RONALD JOHNSON/S			19b. Mailir 10501	ng Address BURT	(Street a ON P	nd Numbe PARK 1	or or Rural DRIVE	Route Number	er, City o BURG	, MD 2	, <i>Zip Cod</i> e 21532	e)
Baltimore,	Pages 1. ment of He ant: if Iten ury or oth		20a. Method of Disposition 1 □Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		te C	Place of Dispo emetery, crer DSTBURG	natory or of	ther place			8-2006		cation - City STBURG		State
Balt	permit. Depart Import eny inj		21. Signature of Funeral Service Lic	Sowos		547 S		FUN	ERAL	HOME	., P.A.	F	W. MAI ROSTBU		REET MD 21532
-	Physician /Medical Examiner		23a. Parf. Enter the disease, or co shock, or heart tailure. List on tmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a	ed the death line.	+	0	e of dying		cardiac or	respiratory ar	rrest,		Inter	roximate rval Between et and Death
8760,	ate be executed hysicien and the burial-transit	ical Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq										
O. Box 6	To the Hoepital or Attending Physicien: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No 9 □ Unknown	23c. It yes, outcon 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 Feta at time of d	I death 3	Ectopic pro					1	23d. Date of Month	delivery Day	Year
۵.	quires that n signed b uld be deta	a	Part II. Dther significant conditions	contributing to death	but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to				use of death?
Division of Vital Records,	The law require ete has been si page 2 should t	Completed									24a. Was autop perfo		24b. Were prior to death	o complet	ndings available ion of cause of
Vita	sicien: certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		50/0		Othe	r-		(Check only o				
ion of	To the Hospital or Attending Physicien: The law within 24 hours effer death. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of li (Month, i		28b. Time of Injury		8c. Injury Work 1 🗆 Y	at ?	28	ne 5 ☐ Resid 8d. Describe h			овсіту)	
Divis	tal or Attendi s efter death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place OL	Injury - At ho etc. <i>(Specif</i>	ome, tarm, str	eet, factory	, office		28	8f. Location (S City or Tox	Street and vn, State	d Number or)	Rural Rou	ite Number,
	To the Hoepital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Ex	Physician: To the be aminar: On the basis and manner	of examina	wledge, death tion and/or in	vestigation,	in my op	inion, deal	d place, as th occurre	d at the time,	date and	place, and c	lue to the d	cause(s)
	To To	2	29b. Signature and title of certifier	29Nu	d		(License	047	8		6	e signed (Mo	06	
	7		30. Name and address of person wh	hmadal	025	Kent	Print) AVE	200	e, (umt	Derla	nd.	MO.	215	102
	Sta Regist		31. Date filed (Month, Da Year)	06 32. Hogi	strar's Signa	Jure	Se s								

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrer		State	of Maryla	•	artmen rtificat				lental H	ygien Reg. N	200	6 2	0799
	Physici	an	1. Decedent's Nam	e (First, Middle, L	ast)							2. Date of D	eath D	ay Year		me of Death
	Physici /Medio		Dzidra	Jagars				T				June				20 P M
	Examir	er	4a. Facility Name (i number)				Location of			4	c. County of De		
	Funeral		Holy Co 5. Social Security N	coss Host lumber 6.	oital Sex	7. Age (In yrs	. last birthday)	If Under	1 Year		24 Hrs.	8. Date of B	irth	9. B	ntgome inhplace (S	ery tate or Foreign
	Director		577-46-	6059	1□M 2√	7	7 Yrs.	Months	Days	Hours	Min.	(Month, E) (Country) Latv:	
	pu *		Usual Residence o 10a. State			100.0	ity, Town or Lo	ocation								de City Limits
	Aaryla Fehor	ō	Maryland		ontgome		•	er Sp	rino	r						Yes 2 No
	28a-	rect	10e. Street and Nu		megome	- L y		10f. Zip)			10g. C	itizen of What C	Country?	
	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-1 ehow ha Modical Examiliar musi bu nutillied at	Funeral Director	1630 Cd	olesberg	Street	t		20	905					Laty	/ia	
	ems 2	ner	11. Marital Status			Decedent Ever in I	J.S. 13.	Was Deced	dent of H	ispanic Ori	gin? (Spe	ecify Yes or N Rican, etc.)	lo-	14. Race - Am Black, Wh		an,
36	or it	by Fu		ied 2 Married	1 ☐ Yes	es 2 √ No , Give		1 🗆 Yes		Specify:		, , , , , , ,		Specify:Wh:		
21215-0036	hour	edb	3X☐ Widowed	15. Decedent's		or Dates:	16a, Dece	dent's Usua	al Occup	ation			16h	Kind of Busines		
215	nin 72 In "ne Medic	Completed	(Spec	cify only highest g	rade complet	ed) ge (1-4or 5+)	(Give	kind of wo DO NOT us	rk done d se retired	during mos	t of worki	ng	100.		aaaa y	
21	d with	Eo	12	mouty (0 12)		JO (1-40/ 54)	Hom	emake	r					Own	n Home	9
nd	be file tal Hy d oth	Be	17. Father's Name		st)							(First, Middl		n Sumame)		
Z a	d Men d Men narke	٩		Ozolins	G 0		405 14 7		(2)			Bremp				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural; or items 23a or 28a-f ehow enjury or other traumatic event, the Modical Examination at any once.		19a. Informant's N			•	-11:							or Town, State,		
	Heall tem 2		Dace G. 20a. Method of Dis	Klimanis position	s/ Daug		Place of Dispo	sition (Nar	ne of			ate		cing, MI location - City o		
JOE	Page ent of			©cremation 3 5 ☐ Other (Spec		om State Met	cemetery, createropolita			-	June	e 15, 2006	276	exandria	. Vii	rainia
altimore,	permit. I Departm Importe eny inju	1	21. Signature of Fi			. 1			_	1				ome Inc		ginia
m	88 18	1) Dan	r (appri	y 144		5	00 Un	iver	sity	Blvc	l., W.,	Si	lver Spi	ring,	MD 2090
	Physician		23a. Part1 Enter shock, crines Immediate Cause disease or condition	(Final		nat clused the dea on each line.					cardiac o	r respiratory	arrest,		Interva	ximate al Between and Death
	/Medical Examiner		resulting in death)	anditions		to (or as a conse										
	be sit	Examiner	Sequentially list could any, leading to it cause. Enter Under Cause (Disease or	erlying	Oue	i to (or as a donse	quence of):									
	icate be executed physicien and s the buriat-transit	хап	that initiated event resulting in death)	s 📕	c. Due	to (or as a conse	quence of):								-	
8760,	sicien buria	鱼田田					,									
687	ficate p phys	edlo			O					-						
Box	death certificate be executed e attending physicien and ind for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 \(\sum \) Yes 2	months?	1 ☐ Li	, outcome of pregr ve birth 2 ☐ Fet regnant at time of	aldeath 3	Ectopic pr						23d. Date of do Month	elivery Day	Year
P.O.		hysl	9 Unknown		9□∪	nknown										
of Vital Records, F	law requires that the de: as been signed by the a 2 should be detached fi	þ	Part II. Other signi Severe De			to death but not re								use contribute 2 ⊊No 3 ☐ F		
000	aw require s been siy 2 should b	Completed	Hyponatr	emia								24a. Wa		24b. Were a	utopsy find	lings available
æ	The ste h page	E O							-			auto pert	formed?	death?		of cause of
/ita	cian: ertifica	Be	25. Was case reference	rred to medical								Check only	one)			
₹	Physician: The I r this certificete ha ral director, page	္	1 ☐ Yes 2√		1		ER/Outpatier		Othe	er: 4 □ Nu				6 ☐Other (Sp.	ecify)	
	ath. r: After	atlon	27. Manner of Dea 1 ⊠Natural 2 □ Accident	5 Pending investigate	on	ate of Injury Month, Day Year)	28b. Time o Injury	M 2	8c. Injury Work 1 🔲 ՝	/at ⟨? Yes 2 □I		28d. Describe	how inju	iry occurred		
Division	or At after of Direction by	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 286. P	lace of Injury - At I uilding, etc. <i>(Spec</i>	nome, larm, str ily)	reet, lactory	r, office		2	281. Location City or To	(Street a own, Stat	nd Number or F e)	Rural Route	Number,
	Hospital	edical	29a. Certifier	1 Certifying F	hysician: To	the best of my kn	owledge, deat	h occurred	at the tim	ne, date an	d place, a	and due to the	cause(s	s) and manner a	s stated.	use(s)
	thin 2-	Med	one) 29b. Signature ang		and n	nanner stated.				number				ate signed (Mor		
)	5 with			_ YVV	nay	W m	1)	230	D635					June 15,		
				ayag, M.	D. 150	00 Forest	t Glen	Road,		ver S	Sprin	ng, MD	2091	10		
*	Sta Registr		31. Date liled (Mor	UN 19	2006	2. Fegistrar's Sign	lature	artie								

			1	For State Registrar	State of M	larylar				lealth and N Death		giene Reg. Ne	7 11110	2	080
	2	Physicia /Medic Examin	an al	1. Decedent's Name (First, Middle Helen Frazer J 4a. Facility Name (If not institution,	eanes			4b. City	, Town, o	r Location of Death	2. Date of De	Da	Year, 2006 C. County of Dea	0 9	ne of Death
		Funeral Director		5. Social Security Number 200-36-8982			last birthday	/) If Under	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da May 21	h y, Year	9. Bir	thplace (Sountry)	tate or Foreig
	polar	how		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	ty, Town or I	ocation							de City Limit
	N e	23s or 28s-f ehow	Director	MD Ceci	l	Eo	vlevi					10 0			1102 5 10/140
	dish T	or 2	D	10e. Street and Number	0 /				ip Code				itizen ol What Co	ountry?	
	the	23	era	1000 Cherry G	12. Was Deceden	t Ever in U	IS 13		1919	Hisnanic Origin? (S	necify Yes or No		SA 14. Race - Ame	erican Indi	an.
C	U36 ure after de	and Mantal Hygiene. and Mantal Hygiene. is marked other than "natural", or items 23a or 28a-f show eumatic event, the Medical Examinar must be cutified at	by Fur	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	Armed Forces	? No		If Yes, sp		dispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)		Black, Whi	te, etc.	,
Č	בֿ בֿ	"natural",	eted	15. Decedent (Specify only highes	's Education		16a. Dec	edent's Us	ual Occup	pation during most of wor	king	16b. l	Kind of Business	/Industry	
3	N 4	e we	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)				during most of word)	J		a. u		
3	ביים ביים ביים ביים ביים ביים ביים ביים	and Mental Hygiene. ie marked other than eumatic event, the M	8	12 17. Father's Name (First, Middle, I	(ast)		Ho	memak	er_	18. Mother's Nan	ne (First, Middle		Own Home	-	
	and	ontal h	Be c	James S. Fraz							2 Osborn		,		
	<u> </u>	t Health and Mer tem 27 ie marke other treumatic	ပ	19a. Informant's Name/Relationsh			19b. Ma	ling Addre	ss (Street	and Number or Ru			or Town, State,	Zip Code)	
	2 2	11th ar 127 io 1 treu		William W. Je	anes, Jr./s	on	10	00 Ch	erry	Grove Ro	ad, Ear	lev.	ille, MI	210	919
	ē,	of Hear		20a. Method of Disposition		20b. i	Place of Disponentery, cr				Date 2006		ocation - City or		ite
		nent cause ant: if ary or		1 ☐ Burial 2 💢 Cremation 4 ☐ Donation 5 ☐ Other (Sp	Decify)					l Home, F		Ri	sing Sur	ı, Ma	ryland
	Battimore, Maryland 21215-0036	perfilit. rages I and a Department of Health a Important: if item 27 is any injury or other trei		21. Signature of Funeral Service	censee					e Street,	T. Foar Chesap	d Fi	uneral H e City,	lome, MD	P.A. 21915
		4 1		22a. Part1. Enter the disease, or shock, a heart failure. List	complications that cause only one cause on each	ed the dear	th. Do not e	nter the mo	ode of dyl	ng, such as cardiac	or respiratory a	rrest,		Interva	ximate al Between
		hysician		Immediate Cause (Final disease or condition resulting in death)	CON	GES	TIVE	- 14	ZAF	TFA	ILURE			3 n	and Death
		/Medical Examiner		C	Due to (or a	TRO	TNT	EST	INA	L BI	<u>EED</u> .			30	ANS
C	,	2 #5	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consec	quence oi):							3 D	AYS.
1/		and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or a										
7		cate be executed physicien and the burial-transit	icai		d		,								
LE	.O. Box 68	ath certification of use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Feta at time of d	al death 3	B⊟Ectopic i ☐ Other (у			23d. Date ol de Month	livery Day	Year
7 1	ds, P.	signed by the a	þ	Part II. Other significant condition	ons contributing to death	but not res	sulting in the	underlying	cause gr	ven in Part I.			use contribute t		e of death?
ES	Vital Record	ne law requir e has been si age 2 should l	Completed								24a. Was autoj perfo	an psy prmed?	24b. Were a prior to death?	utopsy line completion	dings available n of cause of
ANE	ta	ufficet or, pa		25. Was case referred to medical						26. Place of Dea	1 ☐ Yes		lo 1 🗆 Yes	s 2□No)
	5	ysicii is carl direct	To Be	examiner? 1 Yes 2 No	Hospital: 1 Inpa	tient 2] ER/Outpati	ent 3 🗆 [OOA Ot	han	lome 5□Res		6 □Other (Spe	ecify)	
	ion of	anding Physician: The laviath. ath. r: After this certificate has ne funeral director, page 2	atlon: T	27. Manner of Death 1	28a. Date of In (Month, L		28b. Time Injury	ol	28c. Inju Wo		28d. Describe				

20800 3. Time of Death

Approximate Interval Between Onset and Death
3 Months.

29a. Certifier

HOSPITAL, MARYLAND.

5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number D 5 93 98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION RUSTOGI, MD ALOK

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Division of Vital Records To the Hospitel or Attending Physician: The law require

death.

within 24 hours after death.

To the Funeral Director: A completely filled in by the fo Medical

Certification: To

29d. Date signed (Month, Day, Year)

JUNE 17, 2006

			1 - For State Registrar	S	State o	f Marylai			ent of H ate of L			ental Hy	giene Reg. No	$Z \coprod \coprod$	6	2080
			1. Decedent's Name (First, Middle	, Last)								2. Date of De Month	ath Da	ıy Yea		3. Time of Death
	Physicia /Medic		Felicisima B.	Ja	vier							06	15	2000		3-48 AM
	Examin		4a. Facility Name (If not institution	, give stre	et and nu	mber)		4b. C	ity, Town, or	Location of	of Death		40	. County of De	ath	
			Washington Adv	enti	st Ho	spital				a Pai				Montgo	mery	У
F	uneral		5. Social Security Number	6. Sex	1 2 ⊠ F	7. Age (In yrs		If Un Month	der 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year,	9. B	Sirthplac	e (State or Foreign
C	Director		578-11-1994		2001	80	Yrs.					Oct.6,	1925	Phi	lip;	pines
pur	3		Usual Residence of Decedent 10a. State 10b. County			10c. C	ity, Town or Le	ocation							10d	Inside City Limits
Aaryi	e P	ច				,	r - 1	D =1	ı_							1⊠Yes 2 No
the A	288-1	ect	Maryland Montg	omer	У		ľakoma		Zip Code				10a. Ci	tizen of What	Country	?
with	0 2	ā			#4.01											
eath	D 23	era	8308 Flower Ave		#401 Was Dece	edent Ever in l	J.S. 13.	Was De	20912 cedent of Hi		igin? (Spe	city Yes or No		llippin 14. Race - Ar		Indian,
U Z I Z I 3-0030 filed within 72 hours after death with the Maryland	Depertment of Heelth and Mentle Hypjene. Important: If item 27 is marked other than "natural; or iteme 23a or 28e-f show surjoury or other treumatic event, the Madical Examiner must be notified at once. Once.	by Funeral Director	1 Never Married 2 Marr 3 Widowed 4 Divorced		Armed For 1 Yes If Yes, Girl Year or D	rces? 21 %] No /e		If Yes, s	pecify Cuba 25 No	n, Mexicar Specify:	n, Puèrto I	Rican, etc.)		Black, WI Specify:	hite, etc A S 1 8	
2 P	Te le	Completed	15. Deceden	t's Educat	tion		16a. Dece	dent's U	sual Occupa	ation	A = 4 = = dev		16b. k	(ind of Busines		
hin 7	N E S	ple	(Specify only higher Elementary/Secondary (0-12)	ir grade c	College (1-4or 5+)	life.	DO NO	work done d Tuse retired))	t or workii	ng				
N Mit	a the	E O	1				Homen	ake	r				(Own Hom	e	
2	A ST	Bec	17. Father's Name (First, Middle,	Last)						18. Mothe	er's Name	(First, Middle,	Maidei	Sumame)		
should be	TK od	10	Antonino Bac	aro						Pri	mitiv	a No	t A	ailabl	e	
2 sho	and m m		19a. Informant's Name/Relations	hip <i>(Type</i> ,	, Print)		19b. Maili	ng Addr	ess (Street a	and Numbe	er or Rura	l Route Numb	er, City	or Town, State	, Zip Co	ode)
and .	tem 27		Lydia B. Macar	aig	Da	ughter				renue						and 20912
2 S	# E 50		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Per	oval Irom	State 2	Place of Disponentery, cre rge Wa	natory	Vame of or other place	e)	D	ate	20c. L	ocation - City	or Town	, State
mit. Pages	10 TE		4 Donation 5 Other (S		10Vai IIOIII	Geo	orge Wa	shir Cen	igton ietery	J	Jun.2	6,2006	Ade	lphi,Ma	ary1	.and
Dall Dall	y inju		21. Signature o Funeral Service	Licensee		0	F ²	2. Name	and Addres			uneral				
O 8	2 6 8 9		1 inchen		10	le	50	0 U1	nivers	ity I	Blvd.	,W.,Si	lve:	Sprin	g,MI	20901
			23a. Part 1. Enter the disease, or shock, or heart lailure. List	complica only one	tions that o	aused the dea	th. Do not en	ter the n	node of dying	g, such as	cardiac o	r respiratory a	rrest,		In	pproximate terval Between
Ph	ysician		Immediate Cause (Final disease or condition	0	Cox	as ATT	ir he	art	Soil	1101					0	nset and Death
	Medical		resulting in death)	(a	Due to	(or as a conse	quence of):		Ann							
Ex	aminer		Sequentially list conditions,	b	au	ite Co	Relle	00	asu	day	a	cuida	int			
D	=	ner	if any, leading to immediate cause. Enter Underlying	,	Due to	(or as a conse	quence of):									
cute	ind	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	5	epsi	٥								1	
چ چ	urial	ũ	Tesuting in death, cast		Due to	(or as a conse	quence ol):									
cate be executed	physicien and the burial-transit	dicai		d)—(\	4 POL	ensi	m)							-	
A H	ding b		IF FEMALE:	00-	Market	. rati William	181		•					7.77		
ath cer	or us	lan/	23b. Was decedent pregnant in the past 12 months?	230	1 Live t	come of pregr birth 2 ☐ Fet	al death 3		pregnancy					23d. Date of d Month	lelivery Da	ıy Year
9	the f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregr 9∐Unkn	nant at time of	death 5[_ Other	(specify)							•
Pat d	d by detec		Part II. Other significant condition	ons contri	buting to d	eath but not re	sulting in the I	nderkin	G Cause dive	an in Part I		23e Did t	nhacco	use contribute	to the o	cause of death?
i e	sign ed b	d by	Dicheli		1.11	1170	outing at the c	doyiii	g oddso give	J			Yes 2			y 4 🛣 Unknown
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	hes 1	id u	Cosonav	1 OV	rleny	disc	ove					24a. Was	osy	prior to	o compl	findings available letion of cause of
# F	pag.	S		0									rmed?	death'	es 20	□No
	ector	Be	25. Was case referred to medica examiner?		pital:				100		of Death	(Check only o	me)			
P Pys	this at dir	2	1 ☐ Yes 2 ∰ No 27. Manner ol Death		1 🔯	Inpatient 2	Y		DOA Othe	4 🗆 110		ne 5 Resi			oecify)	
in g	After uner	o	1 ANatural 5 ☐ Pendin		(Mon	of Injury th, Day Year)	28b. Time o Injury		28c. Injury Work		-	28d. Describe l	now inju	ry occurred		
Attending	tor:	cat	2 Accident investig 3 Suicide 6 Could	not bo	00 - Di	-41-1 AAA	<u> </u>	М		Yes 2 🗌		201 1	~	(11)		
or A	Dire in by	Certification:	4 Homicide determ	ined	buildi	of Injury - At ting, etc. (Spec	ify)	reet, lac	tory, office		-	281. Location (a City or Tox			Hurai H	oute Number,
pitai	ours filled		29a. Certifier 1 Certifyir	a Physic	ien: To the	hest of my la	nwledge dans	h 000	and at the si-	a date a-	d place	and due to the	02112-1) and =====	20 -1-1	
Hos	within 24 hours etter death. To the Funaral Director: After this certificete hes been signed by the ettending completely filled in by the funeral director, page 2 should be deteched for use as	ledical	(Check only 2 Medical one)	Examine	r: On the b	asis of examin ner stated.	ation and/or in	vestigat	ion, in my op	oinion, dea	ith occurre	ed at the time,	date an	d place, and d	ue to th	e cause(s)
o th	ompl	Me	29b. Signature and title of certifie	r ,					29c. License	number			29d. Da	te signed (Mo	nth, De	y, Year)
-	> - 0		Milial	w	(Y	D.			DE	347	39		6	150	16	
	V		30. Name and address of person	who rom:		-	m 23a) /Tuna	Print)						1 - 10		
			NANDURI KUS	UMA	KAL	YAN1	, 7600	Ca	shoul.	ave	nice	, Takor	nal	Park 1	VID.	
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		_1	For State Registrar	State of Ma	arylan		artmer rtificat					Reg. No.	200	6	208	302
10 A Sec. 188	ysicia	n	Decedent's Name (First, Middle, La: Doris	an P. Jackson	1					1	2. Date of De Month June 7.	Day		ar	3. Time of 0	Death M
	Medica amine		4a. Facility Name (If not institution, give Prince George's Hos				4b. City,		Location o verly	f Death	50.2	4c.	County of D	eath Orge		
Fun Dire	^		240-24-7550	ex 7. Ag. □M 2 🔀 F	e (In yrs. 87	ast birthday) Yrs.	If Unde Months	n 1 Year Days	If Under 2 Hours	Min.	B. Date of Bir (Month, Da April 26	th 1 <i>y</i> , Yea <i>r)</i> 5, 191		Country	ce (State or y) n CaroLi	-
Maryland	lied at		Usual Residence of Decedent 10a. State D.C. 10b. County		10c. Cit	y, Town or Lo	ocation	Wast	ningta	n				100	d. Inside City	
h with the	at be not	Funeral Director	10e. Street and Number 4942 Fast Capital S	Street, N.E.			10f. Zi	Code	20	0019		10g. Citi	zen of What U.S.A.	Countr	y?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23e or 28e-1 ebow	Examiner mu	2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X} \) If Yes, Give Year or Dates:	Ever in U. No		Was Dece If Yes, spe 1 Yes		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	ity Yes or No ican, etc.))-	14. Race - A Black, W Specify:	/hite, et	C.	
Maryland 21215-0036 nd 2 should be filed within 72 hours aft lith and Mental Hygiene. 27 is marked other than "natural", or	na Medical	Completed	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0·12) 12th grade	ducation ide completed) College (1-4or 5	i+)	16a. Dece (Give life. Labo	kind of wo	ork done d	turina most	of working	g		nd of Busine Newsp			ed)
land 2 lid be fited fental Hygi	tic event, I	To Be Co	17. Father's Name (First, Middle, Last,			1			18. Mothe	r's Name	(First, Middle harlott	, Maiden e Davi	Sumame) LS	<u>- </u>		
and 2 should the state of the s	er trauma		19a. Informant's Name/Relationship (Mr. Farl A. Purcell	Type, Print) (San)	1112020	19b Maili 4942	ng Addres East (apita	I Stre	et, N.	Route Numb E. Wash	ingta	n, D.C.	e, <i>zi</i> oc)19	
Baltimore, bermit. Pages 1 ar Department of Hea mportent: If Item	ury or oth		20a. Method of Disposition 1XXSurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Mary	lace of Dispo emetery, cre Land Na	osition (Na majory or ICLOPA	me of other plac Park	. J		, 2006	Lau	rel, Ma	ryla	nd	
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centificate be executed BW/Tamping physician and BW/Tamping physician a	lical iner	Physician/Medical Examiner	23a. Party Enter the disease, or com speck, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each li	ne. Cardia a conseq a conseq	uence of):		de or dym	g, such as	cardiac or	гөэрпатогу а	mest,		- ti	Approximate Interval Betw Onset and De	reen
Box 6 death certif	detached for use as t	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	death 3	⊒Ectopic p ⊒ Other (s					:	23d. Date of Month	,		ear
	pe d	2	Part II. Other significant conditions of Aortic Aneury		ut not res	ulting in the u	ınderlying	cause give	en in Part I.			tobacco u Yes 2 (se contribut		cause of de	
I Rec The law	, page 2 should t	Completed	Osteoporosis								24a. Was auto perfo 1 Yes		24b. Were prior death	to comp	iy findings a pletion of cal	vailable use of
of Vital F Physician: Th this certificate		Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	Hospital:		ER/Outpatie		OA Othe	30		(Check only		2 🗆 🗆	2 6.3		
Vision of Attending Physic death.	e funeral d	ation: To	27. Manner of Death 1XXXI atural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da	ry	28b. Time of Injury		28c. Injun Work	4 🗆 140	28	e 5 Resi			<i>Брөсіту)</i>		
Signal Signal	ed in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et			reet, factor	y, office		28	Bf. Location (City or To			r Rural f	Route Numb	ΘΓ,
To the Hospitel within 24 hours a	ely fiil	edicai	(Check only 2 Medical Example)	nysician: To the best niner: On the basis o and manner st	fexamina	wledge, deat tion and/or in	vestigation	n, in my o	pinion, deal	d place, ar th occurre	nd due to the d at the time,	date and	place, and	due to tl	he cause(s)	
5 this ct	COU	Σ	29b. Signature and title of certific	Tim	m	\sim	29	c. Licenso D3152					e signed <i>(M</i>		ay, Year)	
2			30. Name and address of person who Margaret Appan, M.I	completed cause of co. 6128 Lanc	eath (Iten	n 2324 (Type, Road (h	Print) everly			20785			-, -,			
Re	Stat		31. Date filed (Month, Day, Year) JUN 1 9 200	6 Registr	ar's Signa	iture de	de)									

State of Maryland / Department of Health and Mental Hygiene 20803 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician June 17, 2006 1:25am M Alvart Khatchatourians /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year It Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F Sept 8, 1952 53 Director 213-13-0436 Iran Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Department of Health and Mental Hygiene. Proportiant: If item 27 is marked other then "natural; or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 X No Directo Maryland Montgomery North Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20878 40 Orchard Drive United States Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🛣 No 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: δ 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Administrative Assistant Health Consulting Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျ Tagoosh Safari Avanes Moosakhanian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rostam Khatchatourians/husband|40 Orchard Drive, North Potomac, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jun 21 2006 Germantown, Maryland All Souls Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death metastisis to liver Immediate Cause (Final disease or condition resulting in death) CANCER Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 ☐ Yes To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 DERVOutpatient 3 DOA 1 Inpatient within 24 hours after death.

To the Funers! Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1 [DNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai To the 29d. Date signed (Month, Day, Year) 29b. Signaturg and title of certifier o completed cause of death (Item 23a) (Type, Print) address of person Rockville Medical 1110 SROUR 31. Date filed (Month, Day, Year) 19 JUN 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 2006 7:30 Α June 17, Roland C. Klein /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard 9213 West Stayman Drive Ellicott City 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1**∑**M 2□F Yrs 214 44 9726 Director 6/2/1946 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-1 show item 27 is marked other than "natural", or itema 23a or 28a-1 show other traumatic event, the Nedical Examinar must be notified at 1 ☐ Yes 2 No Ellicott City MD Director Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9213 West Stayman Drive 21042 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. e filed within 72 hours efter II Hygiene. other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Forman Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F is marked of George Klein Margaret Fitch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pernit. Pages 1 and 2 st Department of Health and Importent: if Item 27 is n any injury or other traum 2005. Ijamsville, MD 4605 Distillery Ct. Marie Parraga/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crest Lawn Mem. Gards 6/21/2006

Marriottsville, MD 20a. Method of Disposition 1 28 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pk. Ellicott City, MD 1/emi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARRYTH Priysician CARDIAC MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Due to (or all consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): ettending physicien Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed 2 1 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Assidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Hospital or Attending Pl 24 hours after death. Funeral Director: After the 27. Manner of Death 28d. Describe how injury occurred 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hos within 24 ho To the Fun completely 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific ٤ D0015144 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lute ETERRY CHEUROLET DRIVE, ELLIPOTT CITY, MARYLAND 9055 31. Date filed (Month, Day, Year)
JUN 2 0 2006 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 20805 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** SYED SAFDAR KIRMANT 2006 15 1:30 a June. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9104 Donna La. Howard Laurel 8. Date of Birth (Month, Day, Year) Feb. 22, 1919 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F 87 Yrs. 2**17-**27**-**9975 India Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any indury or other traumatic event. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Md Frederick Frederick 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1817 Rivermist Ct. U.S.A. 21701 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: Asian 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1-4 Architect Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jaffer Syed Kirmani Sajjidia Begum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kirmani/Son 0scar 1817 Rivermist Ct. Frederick, Md. 21701 20b. Place of Disposition (Name of cometery, cromatory or other place)
Md. Nat' I Mem. Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ZNBurial 2 ☐ Cremation 3 ☐ Removal from State June 15, 06 Laurel, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Donald V. Bor wardt Funeral Home, PA
4400 Powder Mill Rd. Beltsville, Md. 20705 23a. art 1. Enter of disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or it art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Atherosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To tha Hospital or Attanding Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2X No 1 Yes : After this certification of the funeral director, it Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2X No Other: 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Aesidence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Yes 2 No investigation 2 Accident Diractor; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0013668 June 15, 2006

Registrar

Docke)

Azhar Hussain, MD 4917 Edgewood Rd. College Park, Md. 20740

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUN 16

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State of	Marylan	•	artment of i rtificate of		na ivi	-	Reg. No. 2 0	06	20806
			1. Decedent's Name	e (First, Middle, I	Lest)						2. Date of Dee	eth	Voor	3. Time of Death
	Physicia /Medica		RUBY 1	LEWIS KENN	1EDY						Month JUN	Dey E 1 3, 200	Year 6	6:30AM
	Examine		4e Fecility Neme (/	f not instituti o n, g	give street and numb	per)			4b. City, Tow	vn, or Loc	ation of Death	4c. County		, J J J J J J J J J J J J J J J J J J J
		ı	GLADYS S	SPELLMAN F	HEALTH CENTE	IR.			CH	EVERL	Y	PRINC	E GEOR	GE'S
	Funeral Director		5. Social Security N 578 30 340	08	. Sex 7. 1 □ M 2 ဩ F	. Age (In yrs. 94	last birthdey) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birtl (Month, Day NOVEMBER	, Yeer) 26, 1911		ace (State or Foreign try) IRGINIA
	and **	-	Usual Residence of 10a. Stete	10b. County		10c. Cit	ty, Town or Lo	ocation					1	Od. Inside City Limits
	Mary f sh	ō	MARYLAND	PRINCE	E GEORGE'S		ВС	WIE						1 ☐ Yes 2 🖾 No
	1 the	Director	10e. Street end Nur		. 0_01101			10f. Zip Code				10g. Citizen of V	Vhet Coun	try?
	38 o		12210 WY	NMORE LANE	1			2	20715			USA		
	death	Funerai	11. Maritel Status		12. Was Decede	ent Ever in U	,S. 13.	Was Decedent of I	Hispenic Orig	in? (Spec	cify Yes or No-		e - Americ	
21215-0020	e su	2	1 ☐ Never Marri 3 ☐ Widowed	ied 2□ Married 4□Divorced		[ŽNo		1 □ Yes 2 ☒ No		, Puerto A	iican, etc.)		k, White, o	
ည	72 ho	ğ	/Snec	15. Decedent's	Education grede completed)		16a. Dece	dent's Usuel Occu	pation during most	of workin	a	16b. Kind of Bu	siness/Inc	lustry
121	han vithin	Completed	Elementery/Seco		College (1-4	lor 5+)	life.	kind of work done DO NOT use retire		or violitini,	9	WD CHE		
2	iled v tygie ther ti	ပိ -	12 17. Father's Neme	/First Middle I e	net)			SALES C	,	's Name	(First Middle	HECHT Maiden Sumam	- 1	
an	ntel l	m	HIRAM		. ,					NES	, , ,		e) UKN	
<u> </u>	should and Man marke umatic	2	19a. Informant's Na		(Type, Print)		19b. Mailir	ng Address (Stree		-	Route Numbe	r, City or Town,	State, Zip	Code)
Σ	and 2 salth ar n 27 ls er trau	1		PHREY - DA				USTIN WAY,						-
ē,	f Hear frem tem	ŀ	20a. Method of Disp				Place of Dispo	sition (Name of matory or other pla			Date	20c. Location -		wn, State
ê E	Peges nent of int: If ite			☐ Cremation 3 5 ☐ Other (Spec	□Removal from Stacify)	ate		LN CEMETER		6/1	L6/2006	BRENTWOO	D. MAI	RYLAND
	Departm Departm Importa any Inju	A	21. Signature of Fu	neral Service Lic	ensee		1	2. Name and Addre	-	,	25		,	
m	9 5 E 8	W	Muze	lint, de	lobert		1 H	INES-RINAL 1800 NEW H	DI FUNEI AMPSHIRI	RAL HO E AVEN	OME, INC NUE. SILV	ER SPRING	. MAR	YLAND 20904
		1			omplications that cau	sed the deat	h. Do not ent	er the mode of dyi	ing, such as o	cardiac or	respiratory ar	rest,		Approximate Interval Between
F	Physician				, E. E. M.								1	Onset and Death
	/Medical Examiner		Immediate Ceuse (disease or conditio resulting in death)	Final n	a. ACUTE	MYOCARI	DIAL INF	ARCTION					1	
	5P	_	resulting in death)				or as a consec							
ele-	nsit				■ b. ——CORON		ERY DISE							
	ificata be executed g physician and es the buriel-transit	edical Examiner	Sequentially list co- if any, leading to in cause. Enter Unde Cause (Disease or that initieted events	nditions, mediate	DIADE	Due to (d TES MELI	or as a consec	quence of):					-	
68760,	a be /sicia e bur	S C	Cause (Disease or that initieted events	injury	C		r as a conseq	uence of):					-	
	fificat g phy es th		resulting in death) I	_ast									í	
Вох	h cer andin r use				■ d									
	deat ed fo	200	Part II. Other signif	icant conditions	contributing to deat	th but not res	ulting in the u	nderlying cause gi	ven in Pert I.		23b. Did to	obecco use cor	tribute to	the cause of death?
<u>Р</u>	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriel-transit	Physician/M									101	∕es 2∏ No	3 🗌 Prob	ably 4 Unknown
S,	ras the signe	Completed by									Ode Week	an autonou	24h Wa	re autopsy findings
Ö	neen	ete									24a. Was e perfor		ava	illable prior to npletion of cause
of Vital Records,	The law ata has t page 2 s	Ē									33000	240	of c	leath?
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ō	Attending Physician: or death. ector: After this cartific by the funeral director,	2	27. Menner of Deat	h	28a. Date of	Injury	28b. Time of					ow injury occurr		/
0	ath. r: Afte	atio	1 ☑Natural 2 ☐ Accident	5 Pending investigat		Day Year)	Injury		Yes 2□N	lo				
	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	289. PIECE 01	f Injury - At hi	ome, farm, str y)	reet, factory, office		21	Bf. Location (S City or Tow	itreet and Number, State)	er or Rura	Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this cartificata has completely filled in by the funeral director, page 2	a Ce	29a. Certifier		Physiclan: To the be									
	ne Ho n 24 h	edicar	(Check only one)	2 Medical Ex	aminer: On the basi and manne		tion end/or in	vestigation, in my	opinion, death	h occurred	d at the time, o	date and place, a	and due to	the cause(s)
	Vithing to the company of the compan		29b. Signature and	title of certifier					se number		2	29d. Date signed		
	Ĺ) Yh	4/1	n			D2:	757	7		6/1	3/0	06
	-7	ĺ		•	o completed cause									
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	Stat Registra	-	31. Date filed (Mon	JUN 1	6 2006 32. He	Istrer's Signa	A A	parle						

			1 - For State Registrar	State of	Marylan		artmer <i>rtificat</i>			and M	lental Hy	giene Reg. No. 2	006	20807
	Physici /Medic	al	Decedent's Name (First, Middle, Last) Juanita		KRUMP	Е	4b Cib	Town	Location of	of Dooth	2. Date of De Month JUNE	17,	Year 2006 unty of Death	3. Time of Death 11:40P.M.
	Examin	er	4a. Facility Name (If not institution, give standard Reeders Memorial 5. Social Security Number 6. Sex	Home		last birthday)	Вос	nsbo			8. Date of Bir	Was	hingto:	place (State or Foreign
·~ .	Funeral Director			M 21K]F		78 Yrs.	Months	Days	Hours	Min.	Dec. 10	1927 1927	Coui	yland
A.	death with the Maryland ms 23a or 28a-f show fourt be notified	ctor	10a. State 10b. County Maryland Washingto	n		y, Town or Lo gersto								10d. Inside City Limits 12∑ Yes 2 ☐ No
JUAN ITA	th with the 23s or 28	al Director	10e. Street and Number 912 Maryland Aven	ue			10f. Zij	Code 21740	0			U.S.	of What Coul	ntry?
SUCA A	<u>ĕ</u> ≅ ₫	by Funeral	11. Marital Status 1 1 Never Married 2 Married 3 WWidowed 4 Divorced	2. Was Decede Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	es? [XNo		Was Dece If Yes, spe 1 ☐ Yes				ecify Yes or No Rican, etc.)		Race - Americ Black, White, ecify: Wh:	etc.
PE	Maryland 21215-0036 ad 2 should be filed within 72 hours atter th and Nental Hyglene. 27 is marked other then "natural", or ite traumails event, the Mudical Examine	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4	or 5+)		kind of wo DO NOT L	ork done d se retired	ation Juring moss Prate		ing		of Business/In	dustry
EUM P	Maryland 212. I 2 should be filed within and Nental Hygiene. I is marked other then reumand event, the Maryland is the Maryland in the Marylan	To Be Co	17. Father's Name (First, Middle, Last) Fred Bowa	rd		, U.Z.	<u> </u>	и ор			e (First, Middle Marior	, Maiden Sur	mame)	
44 .	C 7 1 2		19a. Informant's Name/Relationship (Type Fred E. Krumpe - s		1	11106	6 Pin	ewood	l Cir	cle,	Hagers	stown,	Mary1a	and 21742
NAME	Baltimore, cernit. Pagis 1 a Department of Hee Important: If them any injury or othe page.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)			Place of Disponentery, creates Hil	.1 Cer	neter	У	June 20	e 20,	Hager		Maryland
NA	Balt permit. Departr trimports eny inju		21. Signature of Funeral Service Licenses Find L. V pt 23a. Part 1. Enter the disease; or complice	W	used the deat	4:	15 Ea	st Wi		B1v		erstov		e cyland 21740 Approximate
(bhysicien and bhysicien and bhysicien and street be arranged at the burial-transit	dical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or Due to (or Due to (or	irale	ler	neu	mo	nia	nor	nl.			Initerval Between Onset and Death
(Box (eath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2∐Feta ntattime ofd	I death 3	⊒Ectopic p ⊒ Other (s _i					23d.	Date of delive	ery Day Year
	Cords, P. Cords, P. Cords, P. Cords that the requires that the been signed by should be detacted.	۾	Part II. Other significant conditions conf	ributing to deat	th but not res	ulting in the u	underlying (cause give	en in Part I			Yes 2□N	o 3□Prot	
ļ!	Vital Rec licien: The law certificate has E rector, page 2 s	Completed	25. Was case referred to medical						00 81		1 ☐ Yes	2 No	4b. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
	Division of Vital Records, P.O. I or Attending Physicien: The law requires that the datler death. Director: After this certificate has been signed by the tin by the funeral director, page 2 should be detached.	ation; To Be	examiner?	28a. Date of (Month,		ER/Outpatier 28b. Time of Injury		28c. Injury Work	r: 42 Nu	irsing Ho	h (Check only one 5 ☐ Resi 28d. Describe	dence 6	1-7	(y)
	Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	I Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		, etc. (Specif	(y)					City or To	wn, State)		al Route Number,
	Di To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	er: On the bas and manne	is of examina	wiedge, deat ition and/or in	vestigation	i, in my op	oinion, dea	d place, th occurr	and due to the red at the time,	date and pla	ce, and due to	o the cause(s)
	To Vill		29b. Signature and title of certifier				1	c. License 35	2578	3		6/18/	gned (Month,	Day, Tear)
0	ØH − IS Sta Regist		30. Name and address of person who core DR ROBERT GUEDEN 31. Date filed (Month Day, Year)	ET, 21		DRIVE.			LLE,	MAR'	YLAND 2	1756	(301)	432-2222

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Keough Joseph Μ. 12 2006 4:45 a M June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millersville Anne Arundel Knollwood Manor Nursing Home 8. Date of Birth (Month, Day, Year) Sept. 5,1925 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min 10XM 2□F 80 Yrs. Sept. Pennsylvania Director 197-16-7286 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ul Hygiene. Lother than "natural", or itema 23a or 28a-f show vant, the Nealical Examinat must be notified at 1 Yes XXNo MD Anne Arundel Severn Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21144 USA 334 Council Oak Drive Pages 1 and 2 should be filed within 72 hours after death by Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Affried Folces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1943–65 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Officer U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Is marked Margaret Shepherd Martin Keough 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and I mportant; If itsm 27 is sny injury or other trau once. 334 Council Oak Drive, Severn, MD 21144 Joseph A. Keough (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐Other (Specify) 8-7-2006 Arlington, VA Arlington Nat. Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility atri Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neuman Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, leading to minimal at cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit or Attending Physician: The law requires that the death certificate be executed physicien and resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the attending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) per o 9 Unknown 9 Unknown ģ Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signer should be d Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed certificate 1 ☐ Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: မှ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 4 Dursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) Dirsctor; After th 27. Manner of De th 28b. Time of 28c. Injury al Work? Certification: 28d. Describe how injury occurred 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Dirsc completely filled in by 4 | Homicide to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier (29d. Date signed (Month, Dey, Year) 137 036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. Dans Drue Chester Mis 2/419 2108 32. Pogislrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 5 2006 Registrar

	,		1 - For State Registra AMEND#1, perMD, 6,	State of Many /21/06,DPS,Mo			nt of He			giene Reg. No.	06	20809
The .	Division	g.	1. Decedent's Name (First, Middle, Last)		_				2. Date of De. Month	ath Day	Year	3. Time of Death
N. al	Physicia /Medic		Barabra An	n Llewell	yn	_			June	12	2006	12:30 A ^M
	Examin	er	4a. Facility Name (If not institution, give s			4b. City,	Town, or L	ocation of Death		4c. Cou	nty of Death	
			Montgomery Gener) If I I male	Oln	ey If Under 24 Hrs.	0.0(0)		ntgome	
V.	Funeral		5. Social Security Number 6. Sex	14 OTT F	n yrs. last birthday, Yrs.	Months		Hours Min.	8. Date of Birt (Month, Da	y, Year)	Cou	
*	Director	à I	568-50-5893 Usual Residence of Decedent		00	1			Sept.	10,193	/	CA
	ow et		10a. State 10b. County	10	c. City, Town or L	ocation						10d. Inside City Limits
	Man Fied	tor	MD Montgomer	v		Rock	ville					1 Yes 2 XNo
	h the	Director	10e. Street and Number			10f. Zip	Code	- AH.		10g. Citizen	of What Cou	ntry?
	th wit		4209 Aspen Hill	Road			208	53-2805		Un	ited S	States
	atter death with the Marylar or itsma 23a or 28a-f show it. It or must be notified at	Funeral	11. Marital Status	Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Dece	dent of His	panic Origin? (Sr , Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. R	lace - Ameri	
98	or it		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give			2 X No		, ,	Spe		Mite
21215-0036	72 hours after death with the Maryland naturel, or items 23e or 28e-f show Jigal Exercitor most be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	1 10 0							
5	"nat	Completed	15. Decedent's Educ (Specify only highest grade		(Give	adent's Usu Bikind of wo DO NOT u	al Occupat ork done du ise retired)	ion iring most of wort	king	16b. Kind of	Business/In	dustry
12	filed within Hygiene. other than "	dω	Elementary/Secondary (0-12)	College (1-4or 5+)		Homem				O5-7	n Home	<u> </u>
9	be filed within 72 ho tal Hygiene. d other than "naturesersht, Ine Meulon		17. Father's Name (First, Middle, Last)	•	-	.romom	7	18. Mother's Nam	е (First, Middle,			
an	should be filed and Mental Hygi marksd other matic event, I	To Be	Richard Halsey Be	st				Doris	Albro			
Maryland	2 should and Men is marks aumatic	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mail	ing Address	s (Street ar	nd Number or Ru	ral Route Numbe	er, City or Tox	vn, State, Zip	Code)
	s 1 and 2 should of Health and Men item 27 is marks other traumatic		Dr. Lynn Llewellyn	/ Husband	4209	Aspe	n Hil	1 Road,	Rockvil	le, MD	20853	3-2805
altimore,	item of He		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re		20b. Place of Disponentery, cre	osition (Na	me of other place	, T	Date	20c. Locatio	n - City or To	own, State
E	Page In the page		4 □ Donation 5 □ Other (Specify)	SINOVALITORI STATE	Metropol:			Juite	6 4	Alexa	ndria,	VIrginia
att	permit. Pages 1 Department of H important: If ite sny injury or ot		21. Signature of Funeral Service License	6			nd Address	1.7	eVol Fu	neral 1	Home,	10 East
8	g G E # 9		PRACYA. Uto	iur	I	Jeer J	Park 1	Drive, G	aithers	burg, l	MD 208	177
	Physician /Medical Examiner	iner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury	0	212							Interval Between Onset and Death
,68760,	The law requires that the death certificate be executed ate bas been signed by the attending physician and page 2 should be detached for use as the burial-transit	Medical Examine	Cause (Present of Injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):							
P.O. Box	it the death certifica by the attending plached for use as t	Physiclan/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	Bc. If yes, outcome of p 1 Live birth 2 C 4 Pregnant at tim 9 Unknown	Fetal death 3	⊒Ectopic p ⊒ Other (s				1	Date of delive Month	ery Day Year
	w requires that been signed t should be det	by	Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	, ,	•		23e. Did to			he cause of death?
Vital Records,	itcian: The law certificate has brector, page 2 st	Completed									prior to co death? 1 Yes	psy findings available mpletion of cause of
		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital:	مال دین		Other	26. Place of Dea				
on of	ding After fune	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time o		28c. Injury a Work?	4 🗀 Ivursing no	ome 5 Residence Page 1			(y)
Division	5	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5		reet, factor	y, office		28f. Location (S City or Tow		mber or Rura	al Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Examin	ician: To the best of m ar: On the basis of ex and manner stated	amination and/or in	nvestigation	n, in my opii	nion, death occur	red at the time,	date and plac	e, and due to	the cause(s)
	To To Com	Σ	29b. Signature and title of certifier				c. License			29d. Date sign		
,	5		· Churtof	aepus			U57	173		101	2 12	1206
,			30. Name and address of person who con	mays, m	h (Item 23a) (Type	Print)	ce P	193 Lilia Do	ive di	109,0	us 2	10832
	Sta Registr		31. Date filed (Month, Day, Year) JUN 19 200	32 Registrar's	Signature	ales)	-			-		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** LIVESAY 1:15 P M MAT.FNA CLATR 16 2006 JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Montgomery Gaithersburg If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 21, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🕱 F 577-44-8046 92 Director 1913 Tennéssee Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If tem 27 is marked other then "natural", or Items 924 process. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Gaithersburg 1 Yes 2 □ No Md. Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 301 Russell Ave. #250-B United States Funeral 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🗹 No Specify: White Specify: Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flamentary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 or other treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vista Testerman George Leaman Buena ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 11922 Frederick Rd., Ellicott City, Md. 21042 Helen L. Steinfort/Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crem. 6/17/06 Alexandria, Va. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee P. O. Box 5038, Laytonsville, Md. 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 weeky Physician dehy disease or condition resulting in death) dration /Medical Due to (or as a consequence of): **Examiner** officialia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed? 2. 1 Yes Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ۲ Nursing Home 5 Residence 6 Other (Specify) lhis 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one and manner stated. 29c. License number 29b. Signature and title of certifier No 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) 911 Musical JUHN 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

19

2006

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

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	/Medical Examiner		le Fecility Neme (III			m <i>ber)</i>					City, Town, or	Location of Dee	ith 4	c. County	of Death e Geo	rge	¹ s
	Funeral Director		5. Social Security N 22550-68	umber 6	. Sex 1 □ M 2 ☑ F		(In yrs. lest b	irthdey) Yrs.	If Under 1 Ye Months Day	ar	If Under 24 Hrs Hours Min	8. Date of B		r)	9. Birthp Coun	lace (Ste	ete or Foreign Forge , V
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Ball	permit. Pa Departmen important: any injury once.		21. Signature of Fu	neral Service Lic	ensee MA	-1	· >>					oe Funer Vashingt			0020		
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item 1 - State Registrar #19a, per f.home, 6/2706, Certificate of Death E.T, WCHD Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Christine Elizabeth Lucas June 6:20 AM 20,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY REHAB & NURSING CENTER SALISBURY, MD. 21804 WICOMICO 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day Year) 95 Yrs. Months Days Hours Min. 11/13/1910 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2×F 216-38-7985 0H Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f ehov Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heatih and Mental Hygiene.

ant: If item 27 is marked other than "naturel", or iteme 23a or 28a-1 ehov ury or other traumatic event, it a Madical Exactificat at 1 ☐ Yes 2 No Funeral Director MD Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 213 Ironshire St. 21863 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bfack, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Christine Completed 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry V. Lucas Olive Kellev 19a. Informant's Name/Relationship (*Type*, *Print*)
Ellen Cabler (niece)
Helen Cabler (niece) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6235 Friendship Rd., Pittsville, MD 21850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 6/20/2006 Cape Henlopen Crem. Frankford, DE 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a Part 1. Enter the measurement of complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line Approximate Interval Between Onset and Death tmmediate Cause (Final Pnysician year. cone resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 Yes 2 € No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient Other: 4 Norsing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 3 NO 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 ☐ Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

filled in by the f within 24 hours after To the Funeral Dire

WILLIAM ROBINS, M.D. JUN 2 0 2006

un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

29b. Signature and title of certified

Medical

State

Registrar

200 CIVIC AVE., SALISBURY, MD.

1 Destrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and matther stated. 29c. License number

21804

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible ink
State of Maryland / Department of Health and Mental Hygien

Physici		Registrar		ficate of l	Death		Reg No.		
ical Exami		Decedent's Name (First, Middle,Last) Leonard H. Lo	ockhart, Jr	•		2. Date of De Month June 13	Day , 2006	Year	3. Time of Death 2116 hrs
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Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)					thplace (State or
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Datumore, MD 4.14. permit. Pages I and 2 should be fi perment of Health and Montal Important: If item 27 is marked injury or other traumatic event,	4	21. Signature of fun ral Service Licensee	•	22. Na	me and Address of Fa		100		
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shock, or heart failure. List only	\ /T\.	Fran	ncis J.	Collins	Funeral Ho	me, Inc.						
shock, or heart failure. List only	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.											
	ne cause on each line.	DO HOL BINGS (I	the thode of dying.	, such as cardiac	or respiratory arrest,		Approximate Interval Betwee Onset and De					
	a Intractable S	eizure				40)ovs					
osuming in double,	Due to (or as a conseque	nce of):			1							
	_{b.} Old Motor Veh		cident		1//	¥	cars					
any, leading to immediate ause. Enter Underlying	b. Old Motor Venicle Accident Due to (or as a consequence of): C. Due to (or as a consequence of): d. CERTIFICATION APPROVED BY MEDICAL EXAMINER											
Cause (Disease or injury nat initiated events esulting in death) Last	c Due to (or as a conseque	EDICAL EN										
	<i>D</i> ,											
	d											
F FEMALE:			CERIN	<u> </u>								
3b. Was decedent pregnant 2	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d		topic pregnancy			ery						
in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of dea 9☐ Unknown		ther (specify)			Month	Day Ye					
9 Dunknown	9LI UNKNOWN											
art II. Other significant conditions cor	ntributing to death but not result	ing in the under	rlying cause giver	n in Part I.	23e. Did tobacc	o use contribute to the	he cause of dea					
					1 🗆 Yes	2⊠No 3□Prob	bably 4 □Un					
					24a. Was an	24h Were auto	oney findings av					
					autopsy	prior to co	empletion of cau					
E Man anna antanant an markant					1 ☐ Yes 2√☐ I		2 No					
examiner?	Hospital:		Othor				Hoonic					
12 163 22 10	I □ Inpatient 2 □ Ei				ome 5 Residence	6 ⊠Other (Specif	h)House					
1 'ENatur al 5 ☐ Pending	(Month, Day Year)	Injury	Work?	ar CLIKLOWII	28d. Describe how in	jury occurred						
				es 2 No	Motor vehicl	le Accident						
4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street,	factory, office		28f. Location (Street City or Town, Sta	and Number or Rura	al Route Numbe					
	Unknown			1	Unknown							
9a. Certifier 1⊠ Certifying Phys (Check only 2 Medical Exemis	sicien: To the best of my knowle	edge, death occ	curred at the time	, date and place,	and due to the cause	(s) and manner as s	tated.					
one)	and manner stated.	ii anworinvesti	ugation, in my opii	mon, deeth occur	red at the time, date a	and place, and due to	o the cause(s)					
01 01			29c. License	number	29d. I	Date signed (Month,	Day, Year)					
9b. Signature and title of certifier	2		D 424	52	.T11	ne 15. 200	06					
ep. Signature and title of certifier		00 13, 2000										
I Chile upus	ompleted cause of death (Item 2	3a) (Type Print	nt)									
5	. Was case referred to medical examiner? I. X Yes Manner of Death X Accident 5 Pending investigation 6 Could not be determined 9 Check only one) 1 X Certifying Physical 2 Medical Exemined 1 X Certifying Physical 1 X Certifying Physical 1	it II. Other significant conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to death but	Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient	Was case referred to medical examiner? Hospital: Impatient 2 ER/Outpatient 3 DOA Other	Was case referred to medical examiner? Hospital: Impatient 2 ER/Outpatient 3 DOA Cher. 4 Nursing Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Cher. 4 Nursing Hospital: 1 Nursing Hos	23e. Did tobacc 1 Yes 24a. Was an autopsy performed: 1 Yes 25 No 1 Normal Suicide 4 Homicide 25. Place of Injury 26. Death Check only one 27. Acceptifier (Check only one) 28. Certifier (Check only one) 28. Certifier (Check only one) 29. Certifier (Check only one) 20. Certifier (Check only one) 20. Certifier (Check only one) 20. Certifier (Check only one) 21. Certifier (Check only one) 22. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause and manner stated. 29. License number	23e. Did tobacco use contribute to the significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the significant conditions contribute to the significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the significant conditions of the significant conditions					

### Funeral Director Funeral Director 12436 Legore Road Reymar S. Social Security Number 6. Sex 1 Months	3. Time of Death 2006 3:45p M County of Death Frederick 9. Birthplace (State or Foreign Country) MD 10d. Inside City Limits 1 □ Yes 2 🖫 No
Tuneral Director S. Social Security Number 12436 Legore Road S. Social Security Number 6. Sex 1 Months Days Hours Min. (Month, Day, Year) 90 Yrs. S. Social Security Number 217-10-9086 1 Months Days Hours Min. (Month, Day, Year) 6/17/1916	Frederick 9. Birthplace (State or Foreign Country) MD 10d. Inside City Limits
Director 217-10-9086 1 M 2 F 90 Yrs. Months Days Hours Min. (Month, Day, Year) 6/17/1916 Usual Residence of Decedent	MD 10d. Inside City Limits
0	
To a street and Number 10e. Street and Number 10e. Street and Number 10f. Zip Code 21757 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind 16c. Divorced 10f. Zip Code 21757 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind 16c. Kind 16c. Street and Number 10f. Zip Code 21757 17 Yes of No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16d. Give kind of work done during most of working life. DO NOT use retired) 16d. Street and Number 16d. Street in U.S. 17 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 18 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19 Yes of No- If Yes, Give If Yes, Specify: 10 Yes of No- If Yes, Give If Yes, Specify: 10 Yes of No- If Yes, Specify: 11 Yes of No- If Yes, Specify: 12 Yes of No- If Yes, Specify: 13 Yes of No	
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) As sembly Worker Fairc	4. Race - American Indian, Black, White, etc. Specify: White
Assembly Worker Fairc	d of Business/Industry
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden St. 19. Harry Stoner 18. Mother's Name (First, Middle, Maiden St. 18. Isabel Page	childs Electronics
19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or 7 19b. Mailing Address (Street and Number or Rural Route Number, City or 7 19c. Mary V. Custer Daughter 12436 Legore Road Kemar, MD 21757	Town, State, Zip Code)
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Loca 20c. Loca 20d. Method of Disposition 20d. Place of Disposition (Name of cemetery, crematory or other place) 3 Section 14 Donation 5 Other (Specify) 4 Donation 5 Other (Specify) 4 Donation 5 Other (Specify) 20d. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 4 Donation 5 Dother (Specify)	ation · City or Town, State
21. Signature of Funeral Service Uterisee 22. Name and Address of Facility Keeney & Basford P.A. Funeral 106 East Church St, Frederick,	1 Home
Physician /Medical Examiner Page 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	Approximate Interval Between Onset and Death
IF FEMALE:	d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use	o contribute to the cause of death? No 3 Probably 4 ©Unknown
1 Yes 2 1 Ye	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 No Nursing Home 5 Residence 6 Nursing Home 5 Residence 6 Nursing Home 5 N	
Second S	Number or Rural Route Number,
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one)	nd manner as stated. lace, and due to the cause(s)
047535 6	signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kinghold (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Despirator's Signature	ederich MD 2170

Physic /Medi		Decedent's Name (First, Mid Rose			chows	ski		2. Date of Month		M	. Time of Death 45 am
Exami	ner	4a. Facility Name (If not instituting 1426 Willow C		ber)		. City, Town, or Cumber	r Location of D Tand		Alle	Inty of Death gany	
Funeral Director		5. Social Security Number 745-05-5529 Usual Residence of Decedent	6. Sex 7. 1 ☐ M 2 ☐ χ F	Age (In yrs. last birt		Under 1 Year onths Days	If Under 24 I Hours N	Hrs. 8. Date o	15, 1905	9. Birthplace Country	(State or Forei
a-f show	ctor	10a. State 10b. Coun	egany	10c. City, Town	n or Locatio umbei						Inside City Lim
3a or 28	al Director	10e. Street and Number 1426 Willow C	Court	-	10	Of. Zip Code	21502		1	of What Country?	
yere: Ir the "natural", or itema 23e or 28e-f show the Medical Esabinar must be nutified at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 (Ži Widowed 4 ☐ Divorce	If Vac Cine	es? □XNo		Decedent of H s, specify Cuba Yes 2 No	ispanic Origin? In, Mexican, Pt Specify:	(Specify Yes o uerto Rican, etc.		Race - American II Black, White, etc. Icify: White	ndian,
or than "natu The Medical	Completed		ent's Education lest grade completed) College (1-4	lor 5+)	Decedent's (Give kind life. DO N		ation during most of t)	working	own h	f Business/Industr	ry
d oth	To Be C	17. Father's Name (First, Middle Jacob Zawa	4				Anna	Banas	ddle, Maiden Sum zek Zawa	ski	
if item 27 is marke or other traumatic		19a. Informant's Name/Relation Rosemary Cha	apman dau	ughter 19b	Mailing Ad 1426 V	dress (Street a	and Number or Court	Rural Route Nu Cu	mber, City or Tov	vn, State, Zip Coo	21502
E A		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (n 3 □Removal from Sta (Specify)	20b. Place of cemetery St. Mary	Disposition by crematory y's Cem	n (Name of ry or other place netery	e)	6/26/20	1.	n - City or Town, Derland	State MD
any inj		21. Signature of Funeral Service	e Licensee	Inell-	22. Nan			Home, P		D 21502	
		23a Part1 Enter the disease	or complications that cau	and the death. Do n	not ontor the	108 Virg	inia Avei	nue: Cum	berianu, ivii		
ledical aminer	Examiner	23a. Part1. Enter the disease, shock, or heart lailure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	as a consequence o	STV of): PERT ol):	e mode of dying	g, such as card	fiac or respirato	ry arrest,	App	proximate prval Between set and Death
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as been signed by the ettending physicien and in its should be detached for use as the burial-transit in its part of its part	Cal	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnatin the past 12 moons? 1 Yes 2 No 9 Unknown	a	as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a	of): Pt72T ol): 3 Ectop 5 Other	pic pregnancy	g, such as card	23e. D 1 24a. W	id tobacco use co	Date of delivery wonth Day	Year use of death? 4 Unknowlindings availation of cause of
After this certificate has been signed by the ettending physicien and signed by the ettending physicien and signed funeral director, page 2 should be datached for use as the burial-transit signed by the ettending physicien and signed	To Be Completed by Physician/Medical	Shock, or heart railure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or influry that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 moons? 1	a	as a consequence of the pregnancy of the	of): Pt72T of): Sof): 3 Ectop 5 Other the underly	pic pregnancy er (specify)	on in Part I. 26. Place of E	23e. D 24a. W a pr 1 Ye Death Check on	id tobacco use co	Date of delivery Month Day ontribute to the ca 3 Probably Description of the complet death? 1 Yes 2	Year use of death? 4 Unknowindings availation of cause of
After this certificate has been signed by the ettending physicien and tuneral director, page 2 should be detached for use as the burial-transit of property.	Certification: To Be Completed by Physician/Medical	Shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 moorts? 1 Yes 2 No 9 Unknown Part II. Dther significant conditions are referred examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendiateral 2 Accident 3 Suicide 6 Coulc detended.	a	as a consequence of the pregnancy of the	of): CTOT of): 3 Ectop 5 Other the underly ime of jury M m, street, fa	pic pregnancy er (specify)	on in Part I. 26. Place of E	23e. D 23e. D 1 24a. W a p 1 Ye 28d. Descri 28l. Locatio City or	id tobacco use co Yes 2 No Yes 2 No Yes 3 No Yes 4 No Yes 4 No Yes 4 No Yes 5 No Yes 6 00 Yes 6 00 Yes 6 00 Yes 6 00 Yes 7 No Yes 7 No Yes 8 No Yes 8 No Yes 9 N	Date of delivery Month Day Owner autopsy fi prior to complet death? 1 Yes 2 United When the canon are to complet death and the canon are to complet death and the canon are to complet death and the canon are to complet death and the canon are to complet death and the canon are to complet death and the canon are to complet death and the canon are to complet death and the canon are to complet death and the canon are to complet death and the canon are to complet death and the canon are to complet death and the canon are to complete death and the canon are to complete death and the canon are to complete death and the canon are to complete death and the canon are to complete death and the canon are to complete death and the canon are to complete death and the canon are to complete death and the canon are to complete death and the canon are to complete death are to complete death and the canon are to complete death and the canon are to complete death and the canon are to complete death and the canon are to complete death a	Year use of death? 4 Unknowlindings availation of cause of No
". Her this certificate has been signed by the attending funeral director, page 2 should be detached for use a	To Be Completed by Physician/Medical	Sequentially list conditions and issues or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnar in the past 12 moons? 1 Yes 2 No 9 Unknown Part II. Dther significant conditions are referred to the past 12 moons? 1 Yes 2 No 9 Unknown 25. Was case referred medically referred to the past 12 moons? 1 Yes 2 No 9 Unknown 27. Manner of Death 1 Natural 5 Pend 1 Natural 5 Pend 1 Natural 5 Pend 1 Natural 1 Natural 1 Natural 1 Natural 1 Natural 1 Natural 2 Natural 2 Natural 2 Natural 2 Natural 3 Na	a	as a consequence of the pregnancy of pregnancy of the pre	of): CFOT of): 3 Ectop 5 Other the underly the underly Mrm, street, fa	pic pregnancy er (specify) ying cause give	on in Part I. 26. Place of E	23e. D 24a. W 24a. W 24a. W 25. Death Check on 28d. Descrit 28l. Locatio City or	id tobacco use co	Date of delivery Date of delivery Month Day Ontribute to the ca 3 Probably Description to complete death? Ither (Specify) Street or Rural Role Other or Rural Role Oth	Year Year Unknow Indings availation of cause of No

State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Santford B. Montgomery Jr. 24 10:50 Å JUNE 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY Birthplace (State or Foreign Country)

WV 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year Dec • 29, 1927 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F Months Days Hours Min. Yrs. 234-38-4974 78 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits r than "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐XNo Director Hampshire Shanks 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code P.O. Box 336 26761 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) se filed within al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Instructor Vocational 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental h ပ Santford B. Montgomery Sr. Lena Alverna Loy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Shanks, WV 26761 P.O. Box 336 Wanda Montgomery (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
importent: If Ite
any Injury or oti 6/27/06 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Scarpelli F.H. PA Cresaptown, MD 21. Signature of Funeral Service License 22. Name and Address of Facility McKee Funeral Home Inc. Augusta, WV 26704 P.O. Box 270 amen 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** obstruction mall bowe /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): Box 68760, signed by the attending physicien d be detached for use as the buria Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Dav 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, been si 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tes 2 No 1 ☐ Yes of Vital or Attending Physicien: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 2 No Certification; To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kinger D5620 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland, Maryland 21502 B. Semaan M.D. 900 Seton Drive Husam 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 3 -2006 Registrar JUL

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 1 - State Registra Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 15, 2006 6:45 P. June Moosakhanian Avanes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital ROCKVILLE

It Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Sept. 30,1920 Montgomery Rockville 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 XM 2 ☐ F Director 216-11-9803 85 Iran Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö iteme 23a 19280 Circle Gate Drive, # 202 20874 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Heelth and Mental Hygiene important: if item 27 is marked other than "natural", or item eny injury or other traumatic event, the Madical Expenses. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tailor Self Employed 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Sardar Moosakhanian Zamrout Hirabatian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred Moosakhanian/Son 11716 Tifton Drive, Rockville, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/21/2006 Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) All Souls Cemetery 22. Name and Address of Facility DeVol Funeral Home ure of Funeral Service Licensee 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death tmmediate Cause (Final RESPIRATORY **Physician** FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) use as the burial-transit or Attending Physician: The law requires that the death certificate be executed PNEUMONIA ASPIRATION attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical CORONARY ARTE12+ DISEASE IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? DIABETES HYPERGLYCEMIA 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably VASCULAR DISEASE 24a. Was an 24b. Were autopsy tindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? res 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA Medical Certification: To Within 24 hours effer death.

To the Funeral Director; After thi
completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JUNE 15, 2006 D55054 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KASID 17519 REDLAND ROAD ROCKVILLE 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar 20819 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 14,2006 **Physician** Hazel L. Moore 12:54р м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** National Lutheran Home Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | Dec 13, 1908 Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 579-58-0502 9. Birthplace (State or Foreign 97 1 ☐ M 2 🕱 F Virginia Yrs. Director Usual Residence of Decedent with the Maryland 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene. sont: If item 27 is marked other then "natural", or Items 23a or 28a-f show Lry or other treumatic event, the Medical Examinat must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Montgomery Rockville Director X Yes 2 ☐ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 9701- Veirs Drive 20850 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Creed Sumner Roxy Sumner Ogle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Moore- Son 3501- Windom Road, Brentwood, Md. 20722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Department o Importent: If any injury or once. Cedar Hill Cem. 6/21/2006 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Md. 21. Signature of Funeral Service Libensee 22. Name and Address of Facility Hysong Co., Inc.
6510_16th St. NW. Wash DC
saused the death. Do not ofter the mode of dying, such as ardiac or respiratory arrest, 23a. Part1. Enter the disease, or composhock, or heart failure. List only Approximate Interval Between Onset and Dea Immediate Cause (Final Pnysician accelon niva disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Du-lo (or as a consequence of): Examiner burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a nsequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year 5 Other (specify) the detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles W. Karesh- 9701-Veirs Dr., Rockville, Md. 20850 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 1 9 2006

			1 - For State Registrar	State of Marylar		artment of H rtificate of L			iene 2006	20820
	Dhysioi		1. Decedent's Name (First, Middle, Last,					2. Date of Deat Month	h	3. Time of Death
	Physici /Medio		Margaret P		ning			June	16,2006	4:00P M
	Examin	er	4a. Facility Name (If not institution, give 8231 Bishopsga			4b. City, Town, or		n	4c. County of Deat	
			5. Social Security Number 6. Sec		last hirthday)	White If Under 1 Year		8. Date of Birth	Charle	
	Funeral Director			[™] 2√2 F 91	Yrs.	Months Days		Month, Day,		nplace (State or Foreign untry) Virginia
	ס		Usual Residence of Decedent					POMBET	27,1717	VIIgIIIIa
	show	_	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits
	28a-f	ectc	MD Charle	S h	Vhite	Plains				1 ☐ Yes 2 ☐XNo
	with	Dir	8231 Bishopsga	te Lane		10f. Zip Code 206	0.5	10	Og. Citizen of What Co	intry?
	ne 23	Funeral Director		12. Was Decedent Ever in U	.S. 13. V			pecify Yes or No-	USA 14. Race - Ame	ican Indian
Maryland 21215-0036	s 1 end 2 should be filed within 72 hours after death with the Maryland It Health and Mental Hygiene. It Health and Mental Hygiene. The stream of the stream	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	I	Was Decedent of His f Yes, specify Cubar I □ Yes 2X No	Specify:	o Rican, etc.)	Black, White	
Š O	72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	lent's Usual Occupa kind of work done d	ition	tina	6b. Kind of Business/I	ndustry
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ano	t be filed ntat Hygi ed other event, u	Be	, ,, -, -,					ne (First, Middle, M У Young		
چ	should ind Men ind Men ind Men	င	Charles Proffit 19a. Informant's Name/Relationship (Ty		10h Mailin	a Address /Street a			City or Town, State, Z	- 0.11
	end 2 sho salth and n 27 is m		Michael Mannin	•	La contract					
ē,	s 1 end f Health item 27 other tr		20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of		Date 2	otte Hall	own, State
Ë	Pages net of int: If it		14 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Gat	e of .	natory`or other place Heaven (1/06 S	ilver Spi	ing MD
	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service License	MAAA	4.5				HOME, P.A	0 .
<u> </u>	88 5 5 8	10	Dans C. Ech	nl_	21	1 St. M	lary's A	Ave. La	Plata MD	20646
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death	h. Do not ente	er the mode of dying	, such as cardiac	or respiratory arre	st,	Approximate Interval Between
į	Physician		Immediate Cause (Final disease or condition	Coronar	VA	Moon	10:	Seas	2	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):		/			7.00
	-	5	Sequentially list conditions,	Due to (or as a consequ	cence of					
	uted d ansit	Examiner	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
ó	exec an and rial-tra		that initiated events cresulting in death) Last	Due to (or as a consequ	uence of):					
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	ng pt ng pt a as ti	Med	IF FEMALE:							
gox	death certifi e attending p	an/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1□Live birth 2□Fetal	death 3	Ectopic pregnancy			23d. Date of deliv	
	it the de by the a tached f	Physician/Me	1 ☐ Yes 2 X No 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown	eath 5□	Other (specify)			Month	Day Year
٦.	that the ed by detac	P.	Part II. Other significant conditions con	tributing to death but not resu	ulting in the un	deriving cause giver	n in Part I	23e Did toba	acco use contribute to	he cause of death?
Vital Records,	50 00	d by	Arther to			3011) 11g 32230 givor	THE CITY		2 No 3 Pro	2.4
õ	s been s should	jete			-			24a. Was an	24h Were aut	ppsy findings available
ž	0 - 0	Completed	4444					autopsy performe	prior to co	mpletion of cause of
豆	ician: The certificate rector, pag	BeC	25. Was case referred to medical				26. Place of Deat	1 Yes 2 h Check only one	No 1 ☐ Yes	2 No
		ш, г	examiner? 1 ☐ Yes 2 📉 No	ospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient	Other			ce 6 Other (Speci	(v)
<u> </u>	hysici his cer I direct	ို		28a Date of Injury	28b. Time of	28c. Injury a Work?	at ?	28d. Describe how		
<u>o</u>	hy sign	⊢:⊩	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	Injury	TAOIK:				
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			For State Registrar		State	of Maryla	and / Depa <i>Ce</i>	artment <i>rtificate</i>					giene Reg. No.	06	2082
			1. Decedent's Name	(First, Middle,	Last)							2. Date of Dea	ath		3. Time of Death
п	Physici /Medio			BETTY	VIRC	SINIA	MART	ידא				Month June	Day 17, 2	Year 006	5:59 A ^M
10	Examir		4a. Facility Name (If				111111	4b. City, T	own, or	Location	of Death	0 00	4c. County		
			Freder	ick Me	morial	Hospi	tal	Free	der	ick			Fred	erio	:k
	Funeral		5. Social Security No		. Sex		rs. last birthday)	If Under 1	Year	If Under		8. Date of Birt	h	9. Birthi	place (State or Foreign
	Director		214-36-01	99	1 ☐ M 2 12 F	68	Yrs.	Months	Days	Hours	Min.	(Month, Da) July 22		Mary	vland
	p		Usual Residence of												
	aryla phov	- N	10a. State	10b. County Freder	ick		City, Town or Lo hurmont	ocation						1	0d. Inside City Limits
	Ba-f-	cto	arytand	rreder	ICK		Harmone								1 ☐ Yes Ž No
	h with th	ai Dire	10e. Street and Num 10620 Por		ad			10f. Zip 0					10g. Citizen of U.S.A.	What Coul	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If Itam 27 is marked other then "natural", or items 23a or 28a-f ehow eny injury or other traumatic event. It is Medical Examinal must be maillist at once.	y Funer	faryland 10e. Street and Num 10620 Po 11. Marital Status 1 \(\text{Never Marrie} \)		Armed F	2 No		Was Decede		spanic Ori n, Mexicar Specify:		ecify Yes or No- Rican, etc.)		ce - Americ ck, White, y: wh i	etc.
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			23a. Part1. Enter the shock, or hear	e disease, or co	mplications that	caused the de									Approximate
j.	Physician /Medical		Immediate Cause (F disease or condition resulting in death)	Final	a	مک	graph		P	new	Moss	rei			Onset and Death
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Hecords,	The law requires that the te has been signed by th oage 2 should be detache	þ	Part II. Other signific	T CONDITIONS	contributing to d	eath but not r	esulting in the ur	nderlying cau	se givei	n in Part I.			bacco use conti es 2 ☑ No		e cause of death?
<u></u>	w require been sig should b	Completed		12.	1 ,000	ul Le	Dem			_		-			
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Vital	sicien: The la certificate ha irector, page 2	Be	25. Was case referre examiner?	,	Man-hab			_	T -		of Death	Check only on	7e/		
6	Physicien: this certific ral director,	ှင	1 ☐ Yes 2 ☐ ⊀	16			ER/Outpatien		Other	4 🗀 Nui	rsing Hon	ne 5 🗆 Reside	ence 6 Othe	er (Specify)
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읈	Attending r death. ctor: After by the fune	cati	2 Accident	investigati				М		es 2 🗆 N	No				
_	F 8 F E	Certification;	3 🗌 Suicide 4 🗍 Homicide	6 Could not determine	d 28e. Place	of Injury - At ing, etc. (Spe	home, farm, stre cify)	et, factory, o	ffice		2	8f. Location (St City or Town	treet and Number, State)	er or Rural	Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical C	29a. Certifier (Check only one)	Certifying F	Physician: To the aminer: On the b	asis or examil	nowledge, death	occurred at estigation, in	the time my opi	e, date and	d place, a	nd due to the ca	ause(s) and ma ate and place, a	nner as sta	ated. the cause(s)
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, (30. Name and address	ss of person				,							
		13	James Lee			180 The	omas Joh	nson 1	Driv	re, F	rede	rick, Ma	aryland	217	02
111	Sta	e	31. Date filed (Month	Day 2 Pear) 21	006	⇒uistrar's Sig	ture to	W)							

			1- State of Maryland		artment of H		Mental Hy	giene Reg. No	2006	20822
	Physici	ian	Decedent's Name (First, Middle, Last) Kathryn Farrell Millar				2. Date of De Month	eath Da		3. Time of Death
	/Medi	cal	4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or	Location of Doct	June 9		County of Death	6:45A M
1	Examir	ner	Asbury-Solomons Health Care Cent	er	Solomons				lvert	'
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last 060–10–1838 1 □ M 2√√2 F 96	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	rth ay, Year)	Cou	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	115.	L		Sept.	29 1	909 New	York
	ryland		10a. State 10b. County 10c. City, T							10d. Inside City Limits
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ဖွ	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show ita Nedical Examinar must be notified at	Completed by Funeral Director	1 Never Married 2 Married 1 Yes, Give		Was Decedent of His f Yes, specify Cubar		o Rican, etc.)		Black, White	, etc.
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	be file ital Hy id othe event,	Bec	17. Father's Name (First, Middle, Last) Herbery W. Farrell			18. Mother's Nam Franc				
Maryland	2 should be filed withir and Mental Hygiene. is marked other than eumatic event, Ita Ms	ပ								
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, I'va Medical Examinar must be notified at once.		21. Signature of Puneral Service Licensee		Name and Address					20676
	1200		23a. Part 1. Enter the disease, or complications that caused the death. E shock, or heart failure. List only one cause on each line.							Approximate Interval Between
	Physician	Į.	Immediate Cause (Final disease or condition resulting in death) a. Cavclic c	A	rrhy th	nic			1	Onset and Death
	/Medical Examiner		Due to (or as a consequent	ce of):	,		100 10	0 = 41		
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequent		c caran	o Vas w	ilaria;	Seas.	P	
	ocuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.							
8760,	cate be executed physicien and the burial-transit	I Ex	resulting in death) Last Due to (or as a consequence	e of):						
587	physics the t	edical	d							
Box (death certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant					1	23d. Date of deliv	ery
	The law requires thet the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death		Ectopic pregnancy Other (specify)				Month	Day Year
P.0	thet the		Part II. Other significant conditions contributing to death but not resultin	g in the ur	iderlying cause giver	n in Part I.	23e. Did t	obacco u	se contribute to t	he cause of death?
of Vital Records,	quires the	Completed by	. A		ay dise			Yes 2		
900	e law requit has been s je 2 should	piete	Hypertensive Heart d	isea	se		24a. Was		24b. Were auto	opsy findings available
R		Com	7 (rmed?	death?	mpletion of cause of 2 No
Vita	Physician: this certificanal director,	Be	25. Was case referred to medical examiner?			26. Place of Dea				
of	<u>-</u>	1: To	1 Tes 2 140 1 Inpatient 2 ER/	Outpatient Time of	3 □ DOA Other	4 Nursing H	ome 5 Resident	dence 6	Other (Special	(y)
on	nding Ph th. r: After thi e funeral	ation	27. Manper of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	Work?	es 2 🗆 No	200. 20001100 1	iow injury	y occurred	
Division	r Atts er dea recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (S City or Tox	Street and	d Number or Rura	al Route Number,
0	urs eff urs eff erel Di							ŕ		
	Hosp 24 ho Fune etely f	Medical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)	ge, death and/or inv	occurred at the time estigation, in my opi	e, date and place, nion, death occur	and due to the red at the time,	cause(s) date and	and manner as s place, and due to	tated. the cause(s)
	To the Hospital or Attending within 24 hours efter death. To the Funerel Director: After completely filled in by the funer	Me	29b. Signature and title of certifier		29c. License	number		29d. Date	signed (Month,	Day, Year)
			I kyan c. man	a.	D 50	1653		6 3	200	6
	90		30. Name and address of person who completed cause of death (Item 23) 5851 - Deale Church	1) (Type, F	Print) GXA	N - C.	SUR	MA	H	. 5-10-1
	OV Sta	te	30. Name and address of person who completed cause of death (Item 23: 5851 - Decree Church 31. Date filed (Month, Day, Year) JUN 19 2006	VIFE	N KC	000 7	seare	n	nD. 2	0/1/.
	Registr		JUN 1 9 2006 Block &	1084						

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H	ealth and N Death		ene () (16	208	23
			Decedent's Name (First, Middle, Last)					2. Date of Death			3. Time of	Death
	Physici		Thomas Jeffer	son McRae	2			Month 06		Year 006	7:00	P ^M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City. Town, or	Location of Death	_ 00	4c. County of		7.00	
4	Examin	er	Knoll Wood Comfor	-		Millersy			Anna R		1	
	Francis		5. Social Security Number 6. Sex		e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthola	ace (State or	r Foreian
	Funeral Director			M 2□F	65 Yrs.	Months Days	Hours Min.	(Month, Day, 06/16/	Year) 1940	Count	ry)	
			Usual Residence of Decedent					00/10/	1770	- 20		
	yland **		10a. State 10b. County		10c. City, Town or Lo	ecation				10	d. Inside Cit	y Limits
	Mar.	ţō	DC		Washingto	n					1 X Yes	2 🗌 No
	1 the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Count	ry?	
	3a o		800 Geranium Stre	et. N.W.		20012)		USA			
	within 72 hours after death with the Maryland ene. Than "natural", or Items 23e or 28e-f show he Medical Examinar must be notified at	by Funerai		2. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race	- America		
10	fter of the r	Fu	1 ☐ Never Married 2 ☐ Married	Amed Forces? 1 Yes 2 A If Yes, Give X	10	_		Rican, etc.)	Black	, White, e	tc.	
33	al', o	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give X Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	B1	ack	
21215-0036	2 hou	Completed	15. Decedent's Educ		16a. Dece	dent's Usual Occupa	ation	. 1	6b. Kind of Bus	siness/Ind	ustry	
15	Ne di	pie	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5	(Give	kind of work done o DO NOT use retired	lu <i>ring most of work</i>)	ing				
77	i with	E	Elementary/Secondary (0-12)	4		stment Of	fficer		Private	. Ind	ustrv	
g	Hyg othe	Bec	17. Father's Name (First, Middle, Last)					e (First, Middle, M				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If tiem 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event. It a Medical Examinar must be notified at once.	To B	Thomas Ahigher M	cRae			France	s Coby M	cRae			
2	mar mar	-	19a. Informant's Name/Relationship (Typ		19b. Maili	ng Address (Street a				State, Zip (Code)	
S	Itha Itha 27 is		Helen M. F. Fergus	on / Sist	er 4310	Havelock	Road: La	nham. MD	20706			
တ်	Other Hea		20a. Method of Disposition	011 / 0100	20b. Place of Dispo	sition (Name of			Oc. Location - C		vn, State	
5	80 1 2 5		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	emoval from State	Riverdale	natory or other place	' 1	/2006 R	iverdal	o MI	D	
Baltimore,	it. Portuge intended injury	1	4 □ Donation 5 □ Other (Specify)21. Signatur of Funeral Service License			2. Name and Addres						
ga	permit Depar Impor any ir		21. Signature of Funeral Service License	A.		atney's l		- W856.2-S	31 Geor	_		
	482 e G		(alph Trul	um				wa	shingto			
			23a. i art . Enter e disease, r compile shock, or h art failure. List only on	ations that Bused e cause on each lir	the death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arres	st,		Approximate Interval Betwo	veen
	Physician		Immediate Cause (Final disease or condition		Colun	Cance	_				Onset and D	eam
	/Medical		resulting in death)	Due to (or as	a consequence of):							
	Examiner		Sequentially list conditions b.									
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):							
	cuted	Examiner	that initiated events									
o	exe an ar rial-ti	EX	resulting in death) Last	Due to (or as	a consequence of):							
8760,	cate be executed physician and the burial-transit	dicai	d									
68	iffical g phy as th	0 -	F-2-2								<u> </u>	
Вох	The law requires that the death certific, te has been signed by the attending ploage 2 should be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome		ne . ·			23d. Date	of deliver	у	
m	that the death cer ed by the attendir detached for use	cia	in the past 12 months?	4☐Pregnant at		Ectopic pregnancy Other (specify)			Mont	th (Day Y	'ear
P.O.	of the deby the tached	Jys	9 Unknown	9□ Unknown								
٦	res that igned b be deta		Part II. Other significant conditions con-	inbuting to death bi	ut not resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	cco use contri	bute to the	cause of de	eath?
ds	uires sign Id be	d by						1 🗆 Yes	>ENo	3 🔲 Proba	bly 4 U	nknown
Records,	w requir been si should l	Completed						240 1450 00	045 144			labla
e e	sician: The law certificate has b lirector, page 2 s	du						24a. Was an autopsy perform	pr	for to comeath?	sy findings a pletion of ca	use of
		S								☐Yes 2	2□ No	
Vital	ysician: Is certific director.	Be	25. Was case referred to medical examiner?	anital.		- 04		h (Check only one,				
of		2	Tes 254No	ospital: 1 ☐ Inpatie			4 mursing no	me 5 Residen				
		.uo	27. Manner of Death 1 ➡ Matural 5 ☐ Pending	28a. Date of Injui (Month, Da)		28c. Injury Work	at	28d. Describe how	r înjury occurre	d		
.0	Attending or death, ector: Afte by the fune	ati	2 Accident investigation			M 1 1	res 2□No					
Division	l or Attendi after death, Director: A I in by the fu	Ħ	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Stre City or Town,		r or Rural	Route Numb	70 <i>r</i> ,
	talo rs aft al Di ed in	Certification:										
	hour hour uner ly fill		29a. Certifier Certifying Phys	cian: To the best	of my knowledge, deat	occurred at the tim	e, date and place,	and due to the cau	ise(s) and man	ner as sta	ted.	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	one) 2 Medical Examin	and manner sta	examination and/or in ited.	vestigation, in my op	mion, death occur	eu at the time, dat	e and place, ar	ia aue to t	me cause(s)	
	To the To the comp	Σ	29b. Signature and title of certifier	٨.		29c. License		290	d. Date signed	(Month, D	ay, Year)	
			My / Mill	Lulu			22036		6/12	12001	ما	
/	10)	-	30. Name and address of person who cor	npleted cause of d	eath (Item 23a) (Type	Print)	-			1	-	
1	10/		Clay it Ca	17 Jan	2/UP DIC	1 dural	ruy ()	ishes of	no de	61	9	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	asti 9						
	Registr		IIIN 16 20	06 1000	eath (Item 23a) (Type	ALC: NO						

State of Maryland / Department of Health and Mental Hygiene 20824 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June 14, Gerald Leonard Miller 2006 1:30P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day Year) July 1, 9. Birthplace (State or Foreign Country)
MD Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 1**X** M 2 □ F 217-32-7134 70 1935 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits 28a-f ahow other traumatic avant, the Medical Exerciner reast be nutilied at Frederick Jefferson 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4104 Erv Ct. 21755 USA or itama 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2🔀 No Specify. Specify: White ģ 3 ☐ Widowed 4 M Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 heavy equipment operator construction 12 should be filed w h and Mental Hygier 7 is merked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul K. Miller Olga Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if itam 27 is n any injury or other traun Franklin Miller (Brother) 4104 Erv Ct., Jefferson, MD 21755 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Smithsburg Crematory 6/19/06Smithsburg, MD 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licens Donald B. Thompson Funeral Home 31 E. Main St, Middletown, MD 21769 othe disease, or complications that eart failure. List only one cause on not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Betwee Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical as a consequence of) Examiner HENOS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of) Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Hinknown Other significant condition contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Yes | 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Division of Vital 1 Yes 2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 2 ER/Outpatient 3 DOA 27. Manger of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After To the Hospitei or Attanding within 24 hours after death. To the Funerei Director: After Natural 5 Pending investigation Injury 2 No 1 🗌 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check o one) 29b. Signa Cense number completed cause of death 31. Date filed (Month State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 20825 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Clyde Theodore Norris 20, 2006 /Medical June 4:30 AM 4a Facility Name (ff not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Devlin Manor Allegany Cumberland If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 157 M 2□ F Months Days 98 Yrs. Director 220-10-2220 May 20, 1908 PA Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ₹ No Director **Allegany** Little Orleans 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12712 Divide Ridge Road 21766 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after of artment of Health and Mental Hygiene. ortant: If item 27 ls marked other than "natural", or item injury or other traumatic event, The Medical Examinate injury or other traumatic event, The Medical Examinate. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. þ 3 Widowed 4 □ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Heavy Equipment Operator Road Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick J. Norris Anna Belle Hoopengardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3005 Pleasant Grove Road Warfordsburg, PA 17267
ce of Disposition (Name of Date 20c. Location - City or Town, State Denver A. Plessinger/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Piney Plains U.M. Cemetery 06/22/06 Little Orleans.MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical as the Due to for as a consecution is off Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 3 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? †☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 Yes 2 No 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b Time of 28c. Injury et Work? 28d. Describe how injui√ occurred 1 Natural 5 Pending r death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after deat 6 Could not be determined To the Hospital or Atte within 24 hours after der To the Funeral Directo completely filled in by the 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1/--- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0017565 nene 20 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A-J7301lino ルシモリ 626212 31. Date filed (Month, Day, Year) Registrar's Signature State 2006 Registrar

06-04399 Please Type or Print in Black Indelible Ink Penny Jo Newton State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner PENNY JO NEWTON June 23, 2006 1025 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3809 Light Arms Waldorf Charles 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Cour WASHINGTON, DC Months Days Hours Director DECEMBER 8, 1964 215-94-6137 41 2 **X** F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or items 23a or 28a-f show 1 X Yes 2 No CHARLES WALDORF MARYLAND Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
The file of the marked other than "natural", or items 23a or 28a-f sho or other trannante event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 20602 UNITED STATES 3809 LIGHTARMS PLACE 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 8lack, Armed Forces White etc 1 Never Married 2 X Married Yes 2X No WHITE Yes 2 X No specify 3 Widowed Divorced If Yes. Give Year Specify: ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 HOUSEWIFE 7TH GRADE HOME MAKER 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) DONALD LEE DILLY BONNIE JESSLANE MC QUEEN DILLY Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ MICHAEL L. NEWTON / HUSBAND 3809 LIGHTARMS PLACE, WALDORF, MARYLAND 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department or Important: injury or oth THE HUNTT CREMATORY JUNE 29,2006 WALDORF, MARYLAND Donation 5 Other Specify permit. Departm gnature of Junera Sovice Li THORNION FUNERAL HOME, P.A. 3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND LYDIA C. THORNION JOHNSON M00583 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a Cardiac Arrhythmia Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and /sician/Medical item#23a,27,perME,G857,7/12/06 TT X UNPENDED the attending physician ed for use as the burial -AMENDED Box 68760, IE EEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 V Unknown 9 Unknown Phy Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed' death? ✓ Yes 2 No 1 🗸 2 No To the Hospital or Attending Physician; 25. Was case referred to medical 26 Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient Other₄ 2 ER/Outpatient 3 l doa Nursing Home 5 Residence 6 ✓ Other: Scene 1 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification 1 X Natural 5 Pending 1 Yes 2 No Director: d in by the f 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined within 24 hours a To the Funeral 4 Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME June 24, 2006 30. Name and address of person who completed cause of death (Item 23a)

CAMPLET AND REDUCE OCMF 2006

State

Registrar

Carol Allan, MD

JUN 2

7 200

31. Date filed (Month,

Assistant Medical Examiner

strar's Signature

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Eleanor Lavinia O'Brien June 2006 9:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mt. Airy
If Under 1 Year
Months Days Lorien of Mt. Airy Carrol] 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2X F Hours 220-10-5677 Director 86 June 2, 1920 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c, City, Town or Location other than "natural", or items 23a or 28e-f show vent. It a Mudical Examinar must be multified at 10d. Inside City Limits 1 X Yes 2 ☐ No Directo Maryland Frederick <u>Frederick</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6228 White Oak Drive 21701 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and'2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or itei 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 86 <u>factory</u> worker American Optical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Lee Droneburg Catherine Virginia Kemp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Ellen Brendle, daughter 6228 White Oak Drive, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment o Importent: If ` 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 7/3/2006 Frederick, Maryland 22. Name and Address of Facility Keeney and Basford Funeral Home 21. Signature of Funeral Service Licensee any Yandy. I M00999 106 East Church Street, Frederick, MD 23a. Plrt1. El ter the disease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Renal Failure Years /Medical Due to (or as a consequence of): Examiner Respiratory Failure Chronic Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Anemia Years burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien Physiclan/Medical Diabetes Mellitus Type I Years the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 Other (specify) he 9 Unknown 9 Unknown signed by t d be detach Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ A. Fibrillation and Arrytheias 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an dysphagia with G-tube has page 2 autopsy performed? certificate congested heart failure, HTN 1 ☐ Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 0 Ē 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 2 🗆 No 1 Tes Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signati 29c. License number 29d. Date signed (Month, Day, Year) D54749 June 27, 2006 who completed cause

DHMH 17 Rev 1/2001

State Registrar

6-03644		Please Type or Print in Pleak Indelible Ink				
arbara Ann Ou	tten	Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hy	giene			
		1- For State Certificate of Death Registrar		Reg No.	200	6 2082
Physicia	_		2. Date of Dea	ath		3. Time of Death
Medical Exami	ner	Barbara Ann Outten	Month May 28, 2	Day 2006	Year	2340 hrs
and a second		4a. Facility Name (if not institution, give street and number) Noble Road/Lyden School Road 4b. City, Town, or Location of Death Fredericksburg			county of Death roline	
Funeral Director		5. Social Security Number 6. Sex 1. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of B 11-2	irth(MM/DE 3-196	Foreig	thplace (State or in untry) De1aware
any	H	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
*	۲	DE Sussex Greenwood				1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notiffed at once	Director	10e. Street and Number 10f. Zip Code		10g Citizei	n of What Coul	ntr y ?
the last the		200 S. First Street 19950	-	U.	S.A.	
215-0036 be filed within 72 hours after death with the Maryland mial Hygiene riked other than "natural", or items 23a or 28a-f shrent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto R		0- 14	4 Race - Ameri White, etc.	can Indian, Black,
after de al", or i	by Fu	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify.		SA	pecify Whit	:e
hours a	ed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of wo during most of working life. DO NOT use retire		16b. Kin	d of Business/I	ndustry
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after neut of Health and Mental Hygiene ant: If item 27 is marked other than "natural", or other tranmatic event, the Medical Examiner.	Completed	2 Cleaner/ residental		C1	eaning	
21215-0036 Juld be filed within 7 Mental Hygiene marked other than c event, the Medica		17. Father's Name (First, Middle, Last)				
d be f fental narkee	Be	Leonard Horseman Loretta 19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Ru		*11 = T		7 01-)
MD 2 ad 2 shoul th and b n 27 is n aumatic	၉	Stephanie Outten (daughter) P.O. Box 447 Nassau,			or rown, State	, Zip Code)
Ce, Mill and 2 Health a		20a Method of Disposition 20b Place of Disposition (Name of cemetery,	Date		cation - City or	Town, State
MOF ages ent of nt: If		1 Burial 2 X Cremation 3 Removal from State Crematory of other place) 4 Donation 5 Other Specify: 06-0	01-200	6 De	lmar, I	elaware
Baltimore, permit. Pages I at Department of Hee Important: If ite		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hannigan-Short-Dish	aroon	Funer	ral Hom	e Inc
00 80 E E		Delly Short-Dannagan 1700 West Street Lau	rel. I	e. 19	9956	
Physician /Medical		23a Part I Chief the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	respiratory ar	rest, shock	, or heart	Approximate Interval Between Onset and
Examiner	Ì	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Death
		Sequentially list conditions, b				
	Examiner	if any, leading to immediate Due to (or as a consequence of):				
_ =	xam	events resulting in death) Last C. Due to (or as a consequence of):				
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O, : be ex sician	edic	UNPENDED item#28d.per/ME.g858.8/7/06 TT				-
876 inficate ing phy as the b	Ž/L	IF FEMALE: 23b. Was decedent pregnant in the page 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	су		Date of delivery onth	y Day Year
Box 68760, cath certificate be executhe attending physician and office use as the burial - tra	Physician/Medical	4 Pregnant at time of death 5 Other (Specify)				
J. B.	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	tobacco use	e contribute to	the cause of death?
P.C	d by	_	1 Ye	_	-	ably 4 🗸 Unknown
tal Records, rian: The law require certificate has been si ector, page 2 should by	Completed by		24a. Was			topsy findings available
ecol ne law te has	dmo		auto perfo	ormed?	death?	ompletion of cause of
tal Reco ian: The law certificate has		25. Was case referred to medical 26.Place of Death (Check or		4 NU	1 🗸 Ye	s 2 No
12 i	Be	examiner? Hospital Other		1		

Division of Vita To the Hospital or Attending Physician within 24 hours after death

To the Funeral Director: After this cer completely filled in by the funeral direct

examiner? 2 No 1 🗸 Yes

27 Manner of Death

2 🗸 Accident

3 Suicide

Natural

Homicide 29a. Certifier 1 (Check only one) 2

31. Date filed (Month, Day, Year)

JUN 1

Inpatient 2 28a. Date of Injury FOUND: 5 Pending Investigation

May 28, 2006

(Specify) Local Street

28b. Time of Injury 28c Injury at Work? FOUND: 1 Yes 2 ✔ No 1135 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc.

DOA

Nursing Home 5 Residence 6 🗸 Other: Scene

28d Describe how injury occurred Subject passenger Subject metorcyclist in vehicular accident of motorcycle involved in motorcycle 28f Location (Street and Number or Rural or Town, State)
Noble Road/Lyden School Road, Fredericksburg

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c License number

Other₄

29b. Signature and title of certifier

O.C.M.E.

29d Date signed (Month, Day, Year) May 30, 2006

Name and address of person who completed caus death (Item 23a) Assistant Medical Examiner Theodore King MD.

6 Could not be determined

111 Penn Street, Baltimore, MD 21201

State Registrar

Certification:

Medical

1

32. Registrar's Signature

ER/Outpatient 3

State of Maryland / Department of Health and Mental Hygiene 2 🕦 🕦 👝 20829 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month MARY ELLEN PATTON June 2006 16, 5:12pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA Medical Center LaPlata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2XX 66 Yrs 192-30-8600 Director DEC.25,1939 PENNSYLVANIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r then "natural", or itema 23a or 28a-f ehow the Medical Examinar must be mutified at 1 Yes 2000 MARYLAND CHARLES WALDORF Direct 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 3601 WOODLEY ROAD 20601 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 ☐ Yes ♀∏No If Yes, Give* Year or Dates: 1 Never Married 2 Married or i Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 PROPERTY MANAGER ACTION PROPERTIES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be f h and Mental h JOSEPH KNEIB MARGARET FLEARL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unit of Health an vnt: if Item 27 ie m v or other JAMES R. PATTON-HUSBAND 3601 WOODLEY ROAD, WALDORF, MARYLAND 20601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if Ite
eny injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS CEM. 6-21-06 CHELTENHAM, MD 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** 48 HRS /Medical Due to (or as a consequence of): Examiner CANCER 8 MTHS -UNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of) physician Physician/Medical the attending pl for use as t IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a o 9 Unknown 9 Unknown been signed behould be deta Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ OBSTRUCTIVE PULMONARY DIESE 1 Yes 2 □ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 2 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Phpatient 2 ER/Outpatient 3 DOA After this funeral of 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: s after dec. 1 Satural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and to of certifier 29c. License number 29d. Date signed (Month, Day, Year) JUNE 1, 2006 D 28281 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Nelson V. Benjers, MD 9131 Piscataway Road, Suite 600, Clinton, MD 20735 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 20830 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Joseph Pursley. Lawrence 1915 P /Medical June 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurelwood Care Center E1kton Ceci1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6 Sex **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1∭M 2□F Months Hours Min Yrs. 81 Director 213-28**-**8803 Maryland Usuat Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits **ehow** the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No rector Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ ā Items 23a 88 Russell Road 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No !! ¥es, Give year or Dates: 1945–46 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ges 1 and 2 should be filed within 72 hours after c it of Health and Mental Hygiene. If item 27 is marked other then "netural" or Iten 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Automobile Elementary/Secondary (0-12) College (1-4or 5+) Dealership 11 Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Francis Pursley Stella Mae Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jane S. Clemons/Friend 50 Nottingham Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H.
Important: If iter
any Injury or oth 20a. Method of Disposition June 27, 20c. Location - City or Town, State 1 X Buriat 2 ☐ Cremation 3 ☐ Removal from State Immaculate Conception Cemetery * 4 □ Donation 5 □ Other (Specify) 2006 Cherry Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical ast the attending p IF FEMALE: 23c. tf yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9☐ Unknown Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ as been sig 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page this certificate 1 Yes No : After this certifical funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospitat Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗆 Yes 2 10 1 | Inpatient 2 | ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: / completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medida Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number)54073 26.JUN OL)

State

Registrar DHMH 17 Rev 1/2001 BI) CHIRCHMUS

32. Registrar's Signature

COL

New4512 DE 19720

30. Name and address of person implemented cause of death (Item 23a) (Type, Print)

STORE

teres 31. Date filed (Month, Day, Year) 06-04148 Karen Porter

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		C	ertifica	ate of	Death			Reg. No.				2000
Physicia	43.17	Decedent's Name (First, Middle)	e,Last)						2.	Date of Dea Month	th Day Ye		3 Time of	
ledical Exami	ner	KAREN E.								June 15, 2	2006		2005 I	hrs
		4a. Facility Name (if not institution Court House Point Ro				41	Chesepeak		Death		4c. County	of Death		
								,	L		Cecil	1		
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs	If Under 1 Year Months Days	Min		th(MM/DD/YYY	Y) 9. Birth Foreign	hplace (Ŝta n				
Director		177-60-3557	1 M 2 X F	42	Yrs.		J	Feb 3	1964	Cou	intry) I	PA		
any	-	Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty Town	or Locatio	n						10d Inside	e City Limits
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th the Maryland 23a or 28a-f show notified at once.	Director	MD Ceci 10e. Street and Number	1	CI	iesa	peak	e City		_	1.	0. 0	# 10		, 2 110
or 28s	ie	33 E1k Rd.					10f. Zip Code 21915			- 1'	0g. Citizen of W		TLÀ À	
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ath wittems	uneral	11. Marital Status 1 Never Married 2 X Mar		ecedent Ever in Forces?			Decedent of His s, specify Cuban					e - Americ te, etc.	an Indian,	Black,
erdes , or i	ഥ		1 Yes orced if Yes, Give Y			1 , ,	Yes 2 X No	o o o o ifi u			0		Table 2 4	_
rs aft ural" mine	ē	15. Decedent's Education (Spe	or Dates:		16a		s Usual Occupat		nd of work	k done	Specify: 16b. Kind of Bi		Whit	`6
2 hou "nat	ompleted	Elementary/Secondary (0-12)		(1-4 or 5+)			st of working life.				Comme			
5-0036 Iled within 72 P Hygiene Jother than "" the Medical	칠		4	,	I	nter	ior De	signe	er		Inter			gn
5-0036 lled within 7 Hygiene I other than the Medica	힝	17. Father's Name (First, Middle,	Last)					18.Mother's I	Name (F	ırst, Middle, İ	Maiden Surname			_
215 be file ntal H rked o	e e	Charles E.	Orr					Eliz	zabe	th B	urns			
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relations	hip (Type, Print)		198	Mailing	Address (Stree					vn, State,	Zip Code)	
MD d 2 shc lth and n 27 is		Perry Porte	r (hus	band)	1	33 E	1k Rd.	Che	esap	eake	City,	MD.	219	15
nore, MD 2121 ages I and 2 should be fil nt of Health and Mental I it: If item 27 is marked other traumatic event,		20a. Method of Disposition 1 Burial 2 X Cremation	↑ □ B		b. Place o	of Disposit ory or othe	ion (Name of cer	netery,	D	ate	20c. Location	- City or T	own, State	,
Baltimore, MD 21215-003 permit Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Med		4 Bonation 5 Other Sp		R .	A .	Ferr	is Cre	mato	ry 6	/19/0	6 Wes	t Cr	ieste	er,PA.
Baltir permit B Departm Importa injury o		21. Signarus Funera Service	Censre	9 1 1 2 2		22. Na	me and Address	of Facility						
		(+4) 1 B		M005	510	Gr	iffith	Fune	era]	l Cha	pel, I	nc.	190	174
Physician		23a. Part I. Enter the disease, or	complications that	caused the dea	ith. Do no	ot enter the	mode of dying,	such as card	diac or re	espiratory arr	est, shock, or he	eart	Approxim	nate Interval
/Medical		failure. List only one cause Immediate ause (Final disease	N. S 142-1-1-1-	niuries								- 8		Onset and eath
Examiner		or condition resulting in death)		a consequence	e of):							\neg		
***	L	Sequentially list conditions,	b											
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequence	e of):									
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8760, rificate be executed ng physician and as the burial - transi		IF FEMALE:		s, outcome of pr	egnancy						23d. Date of	f delivery		
	an/	23b. Was decedent pregnant in the past 12 months?	LIVE	birth		Feta	il death 3	Ectopic p	regnancy	<i>y</i>	Month	Da	ay	Year
Box e death co	Sici	1 Yes 2 No 9 V Uni	anaum I	gnant at time of	death 5	Oth	er (Specify)				ł			
, P.O. Box 6 res that the death cer signed by the attendible detached for use	Physicia	Part II. Other significant condit	9 OTIK	nown	t reculting	a in the un	derlying cause o	uven in Part I		23a Didto	bacco use conti	ributo to ti	0000000	f dooth?
P.O.	þ	Tare in Outor organicality	ions contributing	to death but no	resulting	g ar the un	denying cause g	jiveii iii Fait i		-	2 No 3			
rds, requires been sig	ed ed								— /i	24a. Was				
ords aw requii as been s 2 should	Completed	·								autop	sy	prior to co	opsy finaing ompletion of	gs available of cause of
Rec The la	E O									1 Yes		death? 1 ✔ Yes	3 2	No
tal Rection: The certificate ector, page	ø	25. Was case referred to medica						of Death (Ci	heck only	y one)				
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	O B	examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2	ER/O	utpatient	3 DOA	Other N	Nursing H	lome 5	Residence 6	✓ Other:	Scene	
ng Pl	n: T	27. Manner of Death	28a. Da	te of Injury ith Day,Year) D:	- 1	Time of Inj	ury 28c. Injui	ry at Work?	28 Dr	d. Describe	now injury occur fixed object	red		
itend leath. tor:	aţio	1 Natural 5 Pend 2 Accident Inve	JIIIG I	D: 5, 2006	1952	JND: 2 hrs	11	res 2 🗸 N	0	iver auto	iixed object	COMISION		
VIS or Al offer of Direction by	ertification			ace of Injury - A	t home, fa	arm, street	, factory, office b	uilding, etc.	28	f. Location (Street and Numb	er or Rura	al Route No	umber, City
pital Dirital filled	Cert	4 L_ Homicide	rmined (Specif) Local Sti	reet				Co		Road and	Short C	ut Road	, , MD
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use			hysician: To the b											
Fo the vithin ompl	Medical	one) 2 Medical Exa	and manner		n and/or i	nvestigatio	on, in my opinion	, death occur	rred at th	ne time, date	and place, and	due to the	cause(s)	
- > - 0	ž	29b. Signature and title of certifie	er .				29c. Licens				29d. Date sign	ned (Mont	h, Day, Yea	ar)
		1 hoden 1	(Kin	An-	Ti.		O.C.I	M.E.			June 16, 2	:006		
20		30. Name and address of person	who completed ca	ese of death (It	om 23a)	,	1							
20		Theodore King MD.	Assistant Me			111 Pen	n Street, Ba	Itimore, M	1 D 212	01				
S	tate	31. Date filed (Month, Day, Yar)	2006	Registrar's Sign	aurre	Spark	U U							
Regis	trar	2011 7 0	2000	1										

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last)

Physician
/Medical
Examiner

1 - For State Registrar

	Physicia		Elmer Lester PERKI	NS				18 2000 1347 PM				
	/Medic Examin	_	la. Facility Name (If not institution, give street	and number)		4b. City, Town, or L	ocation of Death		4c. County of Dea	th		
			Washington County H	ospital		O	rstown		Washir			
	Funeral Director		5. Social Security Number 6. Sex 1 ☑ M	7. Age (In yrs. I		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, July 17,	Year) 9. Bir	thplace (State or Foreign ountry) Maryland		
			Usual Residence of Decedent									
	how	1. 1	10a. State 10b. County		, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 X No		
	B Ma	cto	Maryland Washingt	on	Boons							
	or 28	Director	10e. Street and Number			10f, Zip Code	1710	10	og. Citizen of What C	ountry?		
	ath w	rai	21405 Ruble Road	Vas Decedent Ever in U.	C 40.4		21713	acifu Vas or No	USA 14. Race - Am-	erican Indian		
	er de Item	Funeral	A A	was Decedent Ever in 0. .med Forces? ☐Yes 2. No	5. 13. V	Vas Decedent of His Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)	Black, Whi	te, etc.		
36	hours after death with the Maryland lural', or Iteme 23a or 28a-f show al Exertimet coult be notified at	è		Yes, Give 'ear or Dates:	1	Yes 2X No	Specify:		Specify:	white		
21215-0036	be filed within 72 hours after death with the Marylan tal hygiene. d other than "natural", or Iteme 23a or 28a-1 show event, I're Medical Exacilirar mart by notified at	Completed	15. Decedent's Educatio (Specify only highest grade cor	n noleted)	16a. Deced	ent's Usual Occupat	ion		16b. Kind of Business	/Industry		
215	within 7 ene. than "n	npie		college (1-4or 5+)	`life. D	OO NOT use retired)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			_£_		
21	e filed within al Hygiene. I other than vent, ILe Mis	Con	12	0	supe	ervisor	18. Mother's Name	/First Middle N	aircraft	mrg.		
Maryland	d be fill antal H ced oth	To Be	17. Father's Name (First, Middle, Last) William Lester Perk	ins				Frances				
aryl	s 1 and 2 should by I Health and Menta item 27 Is marked other traumatic e	٦	19a. Informant's Name/Relationship (Type, I	Print)		•			City or Town, State,			
_	1 and 2 Health (tem 27 I		David Perkins - son					-	vn, Maryla			
ore	of Heal		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Remo	val from State	emetery, cren	sition (Name of natory or other place)		20c. Location - City o			
Baltimore,	Pag tment tant: jury		4 Donation 5 Other (Specify)	Res		en Cemeter				, Maryland		
Bal	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral Service Licensee	Music		Name and Address			FUNERAL HO rstown, Md	-		
	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		23a. Part1. Enter the disease, or complication	ons that caused the death						Approximate Interval Between		
	Physician		shock, or heart failure. List only one ca Immediate Cause (Final	Atherosolie	1 0	nong Vas	· da - 6	7:-0-0		Onset and Death		
14.	/Medical		disease or condition resulting in death)	Due to (or as a conseq	uence of):	J. J.	LUI UT	1132000				
ш	Examiner		Sequentially list conditions b		>5 yes							
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):							
	and trans	Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a conseq	unanan of):							
60,	cien a		youthing in doubly cast	Due to (or as a conseq	derice or).							
68760,	death certificate be executed e attending physicien and id for use as the burial-transit	sician/Medical	d									
Box 6	certif nding use as	/Me		f yes, outcome of pregna					23d. Date of de	elivery		
	a death he atte	cia	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnancy Other (specify)			Month	Day Year		
P.0	t the by the tache	Phys	9 Unknown	9 Unknown						1 -1 -1 -1 -1 -1		
	The law requires that the ste has been signed by th bage 2 should be detache	by F	Part II. Dther significant conditions contrib	uting to death but not res	ulting in the u	nderlying cause give	n in Part I.		oacco use contribute es 2□No 3□F	to the cause of death?		
Records,	plnot s uee	Completed by	Hyp-tensi-					-				
ec	law law law law law law law law law law	nple						24a. Was a autops perfor	n 24b. Were a prior to	utopsy findings available completion of cause of		
<u>=</u>		Co	Santa Company					1 Yes	No 1∐Ye	s 2 No		
Vita	Physicien: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	ital:		t 3 DOA Othe		h (Check only on				
of	Phys r this ral dii	. To	Tes 2 No	1 Unpatient	ER/Outpatier 28b. Time of	3 5 00A	4 1 I I I I I I I I I I I I I I I I I I		ence 6 Other (Sp ow injury occurred	өсіту)		
O	ding th. After	tion	1 Natural 5 Pending 2 Accident investigation	8a. Date of Injury (Month, Day Year)	Injury		? ′es 2 ☐ No					
Division of Vital	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not be determined	8e. Place of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Number or F	Rural Route Number,		
Ö	s afte	Certification:	4 El Hornicide	building, etc. (Special	197		1	ony or rom	i, otato)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (n: To the best of my kno On the basis of examina and manner stated.								
	To the Within 2 To the comple	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (Mor	nth, Day, Year)		
	P S P 0		> SHO HOTCH			000	56965		June 20	2, 2001		
~ ^	H		30. Name and address of person who comp		m 23a) (Type,		+. Hose	to 12	mn 3.	740		
	A S	ate	Stack Kotch M 31. Date filed (Month, Day, Year)	32. Registrar's Sign		riam 3	1,00	SIVWI	, 0 21			
	Regis		JUN 2 0 200	Consu	B. A.	oeste						
					- /							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? 🛭 🗎 🧲 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:40 PM 14 2006 June Robert Ellis Plotner /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Hagerstown er 1 Year | If Under 2 645 Security Road 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Davs Months Hours 1 X M 2 ☐ F Yrs. 68 218-34-3637 Director Sept 5 1937 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ehow the Medical Examiner must be notified at ty∑Yes 2 □ No Funeral Director Hagerstown Maryland Washington 10g. Citizen of What Country? 10e. Street and Number ŏ U.S.A. 21740 645 Security Road tems 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Never Married 2 Married White 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Store Appliance T.V. Technican 12 t. Pages 1 and 2 should be filed with the pages 1 and Mental Hygien trant: If Item 27 is marked other thing yor other traumatic event, In other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Toms Plotner Kemp Vernon E. Plotner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 645 Security Road Hagerstown Maryland 21740 Deanna L. Plotner (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) rtment of Hagerstown Maryland 6-17-06 Rest Haven Cemetery ortant: I 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home permit.
Departre
Imports
any nju 1331 Eastern Blvd. N. Hagerstown Maryland 21742 auchos A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. nset and Deat Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 2 No 1 Yes 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Naturai 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 16, 2006 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) 3H.4+1 11110 Medical Campus Rd., Hagerstown, MD S. L. Hatleberg, MD 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State 20 2006 Registrar

		•	- Stote Amend Item 1	State of Maryland / Deper Dr.,G856,06	epartment of Health and N Sertificate of Death	1ental Hygien Reg. No	2006 20835
	Physicia		1. Decedent's Name (First, Middle, Last)	Geneva Simmons	Price	2. Date of Death Month Da	3. Time of Death
	/Medic	al -	4a. Facility Name (If ngt institution, give str	eet and number)	4b. City, Town, or Location of Death	40	c. County of Death
	Examin	er	Univ of Many	and Medica	Baltimore		NIA
	Funeral Director		5. Social Security Number 314-34-7246 1 N Usual Residence of Decedent	7. Age (In yrs. last birth	Months Davs Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Nakyland
	yland yland		10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	Ba-f et	Director	MD Kert	GALEN	VA	10-0	1 Yes 2 No
	with the		107 West Closs Str	real Ant 17	10f. Zip Code	109.0	itizen of What Country?
	me 23	Funeral		Was Domestont Ever in LLS	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 ie marked other than "naturel", or Iteme 23s or 28s-f ehow other treumatic event, the Medical Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: Black
5-0	72 ho	Completed	15. Decedent's Educa (Specify only highest grade of	completed) (Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	16b. I	Kind of Business/Industry
2121	filed within Hygiene. ther than " int, the We	ошо	Elementary/Secondary (0,12)	College (1-4or 5+)	Cook	90	School
	be filed ntal Hygi od other event, L	Be	17. Father's Name (First, Middle, Last)	Test	18. Mother's Nam	e (First, Middle, Maide	n Sumame) D
Maryland	should be and Mental ie marked o	၉	19a. Informant's Name/Relationship (Type), <i>Print</i>) 19b. 1	Mailing Address (Street and Number or Ru	ral Route Number, City	or Town, State, Zip Code)
Ĭ,	and 2 salth a n 27 io		Constance Kyan	13 3.	11 Spring Koad	M. Hiogo	W, MD 21651
ore	Pages 1 nent of He int: if iten iry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rea	cemetery	Disposition (Name of crematory or other place)	lic lar D	ocation - City or Town, State
Baltimor			4 □Donation 5 □ Other (Specify) 21. Si matura → Funeral Service Licensee	INT. Puas	22. Name and Address of Facility	114/05 HO	WOHOWN, MID
Ва	permit. Departrimports eny inje		Am A. Or	ina	BENNIE SMAKE + U	MALL YOU	ze de
			23a. Part1 Enter the disease, or complications, or heart failure. List only one	ations that caused the death. Do no cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest,	/ Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Vent det	sendend Res	pulator	y 3 weeks
	/Medical Examiner		Testing in death)	Due to (or as a consequence of	11 tumos	failur	l juean
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	y runnows		2
	acuted and transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to locals a consequence of	nsion		>/Oyears
760,	ate be executed only sicien and the burial-transit	ical E		Complet	we Heart 7	aclus	, Igean
89	certificate be execu Iding physicien and Ise as the burial-trai		d.	our igour i	-1/2		
Box	leath certifica attending ph	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal death	N/A 3⊟Ectopic pregnancy		23d. Date of delivery Month Day Year
	0 0 0	Physician/Med	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)		NA
, P.O.	requires that the de een signed by the a nould be detached t	y Ph	Part II. Other significant conditions conti	ributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
rds	w requires been sign should be	ed b	COPD; DI	aletes, =	Excoldosio	1 🗆 Yes	2 No 3 Probably 4 Unknown
Division of Vital Records,		Completed by	Mound o	eliesity		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
alF	hysician: The law his certificate has b I director, page 2 s		25. Was case referred to medical		26 Place of Dea	1 ☐ Yes 2 📉 N	
N S	Physician: this certific al director,	To Be	avaminar?	espital: 1 Inpatient 2 ER/Out	Other	ome 5 Residence	6 ☐Other (Specify)
n O	ng Phys Iter this		27. Manner of Death 1 S Natural 5 □ Pending		ijury Work?	28d. Describe how inj	ury occurred
isio	ttendi death. stor: A	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, far	M 1 Yes 2 No	28f. Location (Street	and Number or Rural Route Number,
Σį	at or A after I Direct d in by	Certification;	4 ☐ Homicide determined	building, etc. (Specify)	inj shooti rasiony) shies	City o Town, Sta	te)
	To the Hospital or Attending Pr within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	edical C	29a. Certifier (Check only one) Cuttifying Trysi	ciant. To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	, and due to the cause, rred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	ro the within in the complex c	Me	29b. Signature and title of sertifier		29c. License number	29d. D	Pate signed (Month, Day, Year)
	. , , , ,) Colle	100	8595	/ 6	/11/06
(3	3)		30 Name and address of person who cor	rpleted cause of death (Item 23a) (Type Print) PIRATES CO	OVE	
	ms	ate	COLUMBIA MD	32. Registrar's Signature	. A.		
	Regist		31. Date filed (Month, Day, Year)	2006			

•		1	For State Registrar	State of Mary		artment of H			iene _{eg. No.} 200 (20836
			Decedent's Name (First, Middle, Las)				2. Date of Deat Month	th Day Year	3. Time of Death
	Physici: /Medic		Dora Le	a Quattro					9, 2006	7:40 P.M
	Examin		4a. Facility Name (If not institution, give		**	4b. City, Town, or			4c. County of Deal	
			Garrett County 5. Social Security Number 6. Se		Hospita	al Oak	land	8 Date of Birth	Garret	
	Funeral Director		5. Social Security Number 6. Security Number 6. Security Number 10 11 Usual Residence of Decedent	M 2 X F 7. Age (///	82 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 04-26-	1924	thplace (State or Foreign ountry) WV
	fand ow		10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	Mary -fsh	ţō	WV Tucker		Davis					Y Yes 2 □ No
	ith the Marylan or 28e-f show	irec	10e. Street and Number			10f. Zip Code		1	Og. Citizen of What Co	ountry?
	th will	E E	5th & Thomas	Ave.		26260			USA	·
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28e-f show any follury or other treumette event, Ite Madical Examinational Legical and once.	골	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 Tho If Yes, Give Year or Dates:			spanic Origin? (Spe n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
21215-0036	hour	Completed by	15. Decedent's Ed		16a. Dece	dent's Usual Occupa	ation	100	16b. Kind of Business	/Industry
15	in 72 n "na	plet	(Specify only highest grad	College (1-4or 5+)	(Give	kind of work done o DO NOT use retired	luring most of workir)	ng		•
212	d with giene	mo	Elementary/Secondary (0-12)	College (1-401 5+)	Hous	sewife			Own Home	<u> </u>
Maryland	uld be file Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Leo William	Lahman			18. Mother's Name		_{Maiden Sumame)} Whitehair	-
lar	sho and h sma		19a. Informant's Name/Relationship (7			-			r, City or Town, State,	Zip Code)
≥,	and sealth		Ernest A. Quat						26260	Town State
ore	ges 1 If ite or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	-	sition (Name of matory or other place			20c. Location - City or	
Baltimore,	tmen tent:				Davis Co				Davis,	WV
Bal	Depar Impor		21. Signature of Funeral Service Licen	klo			ineral Ho 186_Dav:			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the one cause on each line.	death. Do not ent	er the mode of dying	g, such as cardiac o	r respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition		lmonary	Edema				24 hours
	/Medical Examiner	1	resulting in death)	Due to (or as a co	nsequence of):	ve Heart	Foiluro			
		<u></u>	Sequentially list conditions,	b. Due to (or as a co		ve nearc	rallule			one year
\mathcal{F}	rted nsit	Examiner	Sequentially list conditions, if any leading to immunity cause. Enter Underlying Cause (Disease or injury							
· .	be executed ician and burial-transif	Еха	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					
8760	cate be executed oblysician and the burial-transit			d						
9	death certificate e attending phys	hysician/Medical	IE ECMALE.	-7.1.27						
Вох	eath certifica attending ph i for use as th	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pour 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
	that the death ed by the atte detached for	sici	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify)			1113	, , , , , , , , , , , , , , , , , , ,
P.O.	hat the	0	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlving cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Division of Vital Records,	es pe	d by	Atrial Fibrilla	-		, , ,		1 🗆 Y	es 21X No 3 ∏ Pi	robably 4 Unknown
Sor	> 9 5	Completed						24a. Was a	24b. Were a	utopsy findings available
Re	The law ate has b page 2 sl	ш						autops perfor	sy prior to med? death?	completion of cause of
<u>a</u>	icien: Th certificate ector, pag	ပိ	25. Was case referred to medical				26. Place of Death			2 □ No
>	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outpatie	nt 3 DOA Othe	The state of the s		ence 6 Other (Spe	ecify)
10		ı.	27. Manner of Death	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o				ow injury occurred	
ior		atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		,,		Yes 2 □ No			
i×i	or Atter de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, st Specify)	reet, factory, office	2	28f. Location (S. City or Tow	treet and Number or R n, State)	ural Route Number,
	pitel or ours afte erel Dir filled in	S	199							
	Hos Hos Fur tely	edical		ysicien: To the best of mainer: On the basis of exa and manner stated.	amination and/or in			ed at the time, d	late and place, and due	e to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	/	117	29c. License	e number	2	29d. Date signed (Mont	th, Day, Year)
•	-		1 Liter	hour !	N(I)	D272	05		6/10/0x	0
	5		30. Name and address of person who				_1_1 _ 1 _ 1 _ 1 _ 1 _ 1 _ 1 _ 1 _ 1 _	0155	, ,	
			Karl E. Schwalm,		Fourth :		akland, M	D 21550	U	
	Sta Regist	ate rar	JUL 3 - 20	16 Kour	Signature	ank				

			1 - For State Registrar	State of M		Departme <i>Certifica</i>			nd Mental H	ygiene Reg. No	2000	20837	
	Physic	ian .	Decedent's Name (First, Middle, La	•					2. Date of I Month	Da		3. Time of Death	
Y	/Medi		Raheela J. Qures 4a. Facility Name (If not institution, giv		1	4b Cit	v Town or	Location of	1	1	14. 2006 County of Death	1	
	Examir	ner	Saint Joseph	Medical	Center	A	y, 10 4 11, 01		WSON	40.	*	imore	
A.	Funeral		5. Social Security Number 6. S		ge (In yrs. last bir	thday) If Und Month	er 1 Year S Days	If Under 2 Hours		Birth Day, Year)	9. Birth	place (State or Foreign	
* 1	Director		013-/0-56//	☐M 2反F	29	Yrs.	Days	Tiours	May 2				
	and w		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location						10d. Inside City Limits	
	Marylan f show	ō	MA Essex		۸	ndover						1 ☐ Yes 2 ☑ No	
	r 28s	Director	10e. Street and Number		All		ip Code			10g. Cit	izen of What Cou	ntry?	
	th with		8 Orchard Crossin	Ø			015	810			IISA		
	eme r dea	Funerai	11. Marital Status	12. Was Deceden Armed Forces		13. Was Dec			in? (Specify Yes or N Puerto Rican, etc.)	lo-	14. Race - Ameri Black, White,		
36	or it	by Fu	1 Never Married 2 Marned	1 ☐ Yes 2 🔀 If Yes, Give			2 K No		r delto modil, etc.;		Specify:	etc.	
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or itema 23a or 28a-1 ahow ta Mydigal Enatrical for crafitied at	d b	3 Widowed 4 Divorced	Year or Dates:	10-						Asia		
5	in 72	Completed	15. Decedent's E (Specify only highest gra	de completed)		. Decedent's Us (Give kind of v life. DO NOT	vork done o use retired	ation during most	of working	16b. K	ind of Business/In	ndustry	
212	iene.	E O	Elementary/Secondary (0-12)	College (1-4or	1	udent		,		Fdu	cation		
	be filed within 72 hours after death with the Maryla ital Hygiene. id other than "natural", or itama 23a or 28s-1 ahov avent, the Mydigal Examinar must be motified at	BeC	17. Father's Name (First, Middle, Last,		1,00	ducire		18. Mother	's Name (First, Midd				
<u>Ja</u>	2 should be filed withir and Mental Hygiene. ie marked other then eumatic event, I.e.Ms	10	Hamid Qureshi					Zari	na Sidd	iani			
Maryland	2 sho		19a. Informant's Name/Relationship (Type, Print)	19b	. Mailing Addre	ss (Street a	and Number	or Rural Route Num	ber, City o	or Town, State, Zij	Code)	
	nit. Pages 1 and 2 should artment of Health and Men ortent; if item 27 te marke injury or other traumatic.		Hamid Qureshi	Father	8	Orchard	Cros	ssing	Andover,	Massa	chusetts	01810	
Baltimore,	Pages I		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑		cemeter	ry, crematory of Men	other plac	e)	Date	20c. Lo	ocation - City or To	own, State	
Ħ	it. Partimer result in Jury		4 □Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		KHOTTW	Pa	ırk	Ju	n.17,2006	Car	iton,Mass	sachusetts	
Ba	permit. Pages 1 and 2 Department of Health a important; if item 27 is any injury of piper tre once.		21. Signature of Funeral Service Licer	(i L D		Franci	and Addres .Ş J.	s of Facility	ns Funera lvd.,W.,S	l Hom	e. Inc.		
			23a. Part1. Enter the disease, or com	plications that cause	d the death. Do r	500 Un	ivers	<u>sity B</u> g. such as c	Ivd., W., S	ilver	Spring,	MD 20901 Approximate	
	Physician		Immediate Cause (Final	one cause on each	iirie.			16/4	D WALL C			Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a	G-HYPO		G	110/2	of any				
	Examiner		Conventially list annulations	b		,	0	7	8. 6				
100	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence	of):	0.	> ~	32. 0				
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c			AL.	St.	W r				
8760,	cate be executed physician and the buriat-transit		Tooling in County Subt	Due to (or as	a consequence	of):	20 7	2 / 2	Lunie of				
687	physicate physicate	dicai	•	d		176	VC	C sh	1				
ox 6	The law requires that the death certificate be executed tie hes been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy			120	V		23d. Date of delive		
Ď.	death a atte	cia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant a	2 Fetal death	3 □Ectopic 5 □ Other (V		1	Month Month	Day Year	
P.0	that the ded by the	hys	9 Unknown	9□ Unknown									
	es tha igned be de	by P	Part II. Other significant conditions of			the underlying	cause give	en in Part I.	23e. Did	tobacco u	ise contribute lo ti	he cause of death?	
ord	w requir been si should I	ted	MULTIPLE PESONAL	TY DISORD	ER				1	Yes 2	Prob	bably 4 Unknown	
Records,	e taw r hes be	Completed	POST TRAUMATIC ST	RESS DISC	RDER				24a. Wa	s an opsy	24b. Were auto	psy findings available mpletion of cause of	
E		Con								formed?	death?	2 No	
Vital	Physician: T this certificat ral director, p	Be	25. Was case referred to medical examiner?	Hospitat:	A 49		0#		of Death (Check only				
o	9 v =	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Inj		tpatient 3 🗆 [4 🗀 Nurs	sing Home 5 Re			ý)	
Ou	ding Phy th. After thi funeral of	tion	1 Natural 5 Pending 2 Accident investigation	(Month, 9)	ay Year) Ir	njury M	28c. Injury Work	res 2 A	28d. Describe	row injur	Sul Ci De		
Division	l or Attanding after death. Diractor: After I in by the fune	Certification:	3 Suicide 6 Could not b	28e. Place of In	jury - At home, far	7.7			28f. Location	(Street an	d Number or Rura	al Route Number.	
á	Dir	Serti	4 Thomicide	building, e	tc. (Specify)	,	,,,		City or T	Onun:	Power	HOSPITHY	
	To the Hospital within 24 hours and to the Funeral I completely filled		2 Medical Exal	ysicien: To the besi	of my knowledge	death occurre	d at the tim	ie, date and	place, and due to the	a causo(s)	and manner as s	tatad	
	di i	Medical	one) 29b. Signature and titte of certifier	and manner s	tated.								
	T With		A A	_/		2	9c. License		<u>.</u>	/	te signed (Month,	usy, rear)	
	7		30. Name and address of person who	complete Cause	death (Itom 02=)	Type Print	D 00	15458	-	, p	115/06		
			C. TIMOTHY BESS	//			יידמת	e ro	ICON HARM	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	/		
大	Sta	ite	31. Date filed (Month, Day, Year)	32 Regist	rar's Signature	USLEK	DKIV	E_IU	SON_MAR	XTUN	D 21204		
	Regist	ràr	JUN 192	006 A	is S.	ANDREAL)	y*						

Buttal 2 Removal from blate Approximat				For State Registrar	State	of Maryland	-	artment o			Menta		ne 2	0006	2	0838
ROBERT VINCENT ROLLINS From or Liverien of Death PORT TOBACCO CHARLES FOR 10 FOR 1				1. Decedent's Name (First, Middle	, Last)								Day	Year	3. Tim	e of Death
## Facility Name of Principles (Control of Death 1997) Fundamental Principles				ROBERT VI	ICENT F	ROLLINS					JU	NE 2		2006	1	:20PM
Social South February February Personal Control of State						ımber)					th			•		
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The state of the s				·							. (Mc	onth, Day, Y		Co	untry)	
100. State 100. Curry 100. City 100		Director	}			82					AP	KIL	29,	1924	VIRG	INIA
ALICE MAE MARTIN 13a. Intermant's Name-Relationships (Type, Print) 13b. Malling Address (Street and Number of Plumi Route Number, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street and Number of Plumi Route Number, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street and Number of Plumi Route, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street and Number of Plumi Route, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street and Number of Plumi Route, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street and Number of Plumi Route, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street and Number of Plumi Route, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street and Number of Plumi Route, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street and Number of Plumi Route, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street And Number of Plumi Route, Clay or Town, State, 20 Code) Deboration Story or Town, State, 20 Code) METROPOLITIAN CREMATORY 6-2-2-06 EXAMINITE 20b. Malling Address (Street And Number of Plumi Route, Clay or Town, State, 20 Code) 20b. Address (Street And Number of Plumi Route, Clay or Town, State, 20 Code) 20b. Ball of Route, Clay or Town, State, 20 Cod		and and				10c. City,	Town or Lo	cation							10d. Insid	e City Limits
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ALICE MAE MARTIN 13a. Intermant's Name-Relationships (Type, Print) 13b. Malling Address (Street and Number of Plumi Route Number, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street and Number of Plumi Route Number, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street and Number of Plumi Route, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street and Number of Plumi Route, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street and Number of Plumi Route, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street and Number of Plumi Route, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street and Number of Plumi Route, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street and Number of Plumi Route, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street and Number of Plumi Route, Clay or Town, State, 20 Code) DEBORA STORYY-DAUGHTER 20b. Malling Address (Street And Number of Plumi Route, Clay or Town, State, 20 Code) Deboration Story or Town, State, 20 Code) METROPOLITIAN CREMATORY 6-2-2-06 EXAMINITE 20b. Malling Address (Street And Number of Plumi Route, Clay or Town, State, 20 Code) 20b. Address (Street And Number of Plumi Route, Clay or Town, State, 20 Code) 20b. Ball of Route, Clay or Town, State, 20 Cod	2	after or It			ied 1⊠Yes If Yes. G	2 □ No ive		_				,	S			
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Physician Middled Gaus (Final List of the death.) 22a. Part I. Early the death completed the model of the mo	<u> </u>	rmit. ports ports y inju		21. Signature of Funeral Service		MOO	470 22	. Name and A	Address	of Facility						
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Prysician / Middled Examiner Barbor of Course (Final deserver) Barbor of Course (Fin				23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the death.	Do not ent	er the mode to	of dyling	such as cafdia	to or feshi	atory arrest	40		Interval	Between
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Due to (or as a consequence of):		led Isit	nine	cause. Enter Underlying Cause (Disease or injury		(0) 43 4 001136406	1100 017.									
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27. Manner of Death Part of the property of	5	ician certif rector	00	examiner?	Hospital				Othe	-		_		70		
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State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Certificate of Death	R	2000 2000 deg. No.
Physicia edical Examir		Decedent's Name (First, Middle, Last)	= R-hinalla	2. Date of Dea Month	Day Year 0707 I
euicai Exaiiiii		4a. Facility Name (if not institution, give street and nu	mber) 4b. City, Town, of	June 24, 2 r Location of Death	4c. County of Death
		Memorial Hospital	Cumberlar	d	Allegany
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Ye Months Da		rth(MM/DD/YYYY) 9. 8irthplace (State or Foreign
Director	ć	132-06-1130 12M 2DF	Yrs. World's Da	ys Hours Will. II/lay	4, 1959 Country) MD
any	-	Usual Residence of Decedent 10a. State 10b. County	10c City, Town or Location		10d Inside City Limits
* .		WW Mineral	Ridgelen		1 Yes 2 No
Aaryland 28a-f show 1 at once,	Director	10e. Street and Number	10f Zip Code	1	10g. Citizen of What Country?
the M		Route 1 Box 103	C 24	753	USA
death with the Maryland or items 23a or 28a-f sho must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed F		ispanic Origin? (Specify Yes or No n, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, 8lack, White, etc.
er dear		3 Widowed 4 Divorced If Yes, Give Yes	2 X No 1 Yes 2 No	o specify:	Specify: // hite
urs aft tural'	a p	or Dates: 15. Decedent's Education (Specify only highest gra	le completed) 16a. Decedent's Usual Occup	ation (Give kind of work done	16b. Kind of Business/Industry
6 '72 ho	leted	Elementary/Secondary (0-12) College (-4 or 5+) during most of working lift	e. DO NO1 use retired)	Charles 1
5-0036 led within 7 Hygiene. I other than	Comple	17. Father's Name (First, Middle, Last)	7/190710	18,Mother's Name (First, Middle,	Maiden Surname)
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland 1 and Mental Hygene. 27 is marked other than "natural", or items 23a or 28a-f she 1 market other than "natural" or items 25a or 28a-f she 1 market other than "natural".	Be C	K. Broald Robins	He	Anna May (h	FRA Brivan
21, ould b d Men s mar fic eve	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Stre	et and Number or Rural Boute Nur	mber, City or Town, State, Zip Code)
MD 2 sho alth and 2 is 27 is aum af		Diane III Konnette- 20a. Method of Disposition	20b. Place of Disposition (Name of c	Date Place	20. Location - City or Town, State
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" injury or other traumatic event, the Medical Examin		1 Burial 2 Cremation 3 Removal fr	and the state of t	alas / laslas	20. Education - City of Town, Grate
o a ge o	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Nathe and Addre	S OLEACIFIC	Fort Ashby, WV
Balt permit Departu Import injury		Ulicholan 4 Ma	scarpell	E Freneral Horn	m porland, MD 21502
Physician		23a. Part I. Enter the disease, or complications that of failure. List only one cause on each line.	aused the death. Do not enter the mode of dying	, such as cardiac or respiratory arr	rest, shock, or heart Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Methado	one intoxication		Death
		h	consequence of):		
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a cause Enter Underlyin, Cause	consequence of):		
	Examiner	(Disease or injury that initiated	consequence of):		
recuted and transit		d			
ial ial	/Medical	X UNPENDED AMENDED	item#23a,27,28a-f,perME,g	858,8/14/06 TT	174
8760, tificate bug physic as the bug		23b. Was decedent pregnant in the	outcome of pregnancy irth 2 Fetal death 3	Ectopic pregnancy	23d. Date of delivery Month Day Year
Box 687 e death certifi the attending ed for use as t	sician	4 Van O Na O Ulakanua	ant at time of death 5 Other (Specify)		
that the dened by the detached for	Phys	Part II. Other significant conditions contributing t		given in Part I. 23e. Did to	obacco use contribute to the cause of death?
ords, P.O. w requires that the same of the signed by should be detactionally be detactionally be detactionally be detactionally be detactionally be detactionally be detactionally be detactionally be detactionally be detactionally be detactionally be detactionally be detactionally by the same of the same o	è		·	1Ye	es 2 🗸 No 3 🗌 Probably 4 🗍 Unknown
Division of Vital Records, rate dear the law requires at the dearth Appendix The law requires a forest dearth. After this certificate has been sited in by the funeral director, page 2 should be	Completed			24a. Was	, , ,
Recol The law icate has	duc		······································	perfo	ormed? death? 2 No 1 Yes 2 No
tal Recition: The certificate	ø	25. Was case referred to medical	26.Pla	ce of Death (Check only one)	
on of Vital I lending Physician: ath. or: After this certifi the funeral director,	To B	Tes 2 NO	Inpatient 2 ER/Outpatient 3 DOA	Other Nursing Home 5	Residence 6 Other.
n of V ding Ph. h. After t			, Day,Year)	Y 0 N-	how injury occurred
isior Attend er death rector: by the	icati	2 Accident Investigation 28e. Plan	e of Injury - At home, farm, street, factory, office	huilding etc 28f Location (Street and Number or Rural Route Number, City
Divis pital or At ours after d eral Direc	Certification:	3 Suicide 6 X Could not be determined (Specify	House	or Town, S Ridgelev	State) Rt. 1 Box 103 C
		29a. Certifier 1 Certifying Physician: To the be	st of my knowledge, death occurred at the time,	date and place, and due to the cau	ise(s) and manner as started.
To the Hos within 24 h To the Fur completely	Medical	and manner			
	2	29b. Signature and title of certifier		se number	29d. Date signed (Month, Day, Year) June 25, 2006
		30. Name and add ss of person who completed cau			
				Baltimore, MD 21201	
St	ate	31. Date filed (Month, Cay, Sear) 2006 32.	egistrar's Signature		
Regist		43 13 43 2 4 4 7 11 2			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death Month **Physician** 6:05 PM /Medical 4a. Facility Name (If not institution, give street/and number) Ab. City, Town, or Location of Death County of Death Examiner Ton 011 If Under If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number-7. Age (In yrs. last birthday) 6. Sax 8. Date of Birth (Month, Day, **Funeral** Months Davs 1 X M 2 ☐ F 05-889 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits with the Maryland 10b Counts r 28a-f show 10a State 1 Yes 2 □ No Directo 10g. Citizen of What Country? 10e. Street and Number 2000 1 rsi', or items 23a or : Exaction musi be n U.S.A Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married BlACK 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced "natursl" other than "natur vent, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) U.S. Governmen Elementary/Secondary (0-12) College (1-4or 5+) 17 is marked othe traumatic svent, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental har ပ္ 19b. Mailing Address (Street and Number or Rural Routs Number, f Health a Item 27 is other tra 4505 20b. Place of Disposition (Name of cemetery, crematory or other Date 20c. Location - City or Town, State 20a Method of Disposition Department of H Important: If Ite sny Injury or oth once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) emptery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 28a Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on se that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. atera Immediate Cause (Finaf Meumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate 1 Yes 2 No After this certification, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 1 /Inpatient Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 □ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director; Al
completely filled in by the fu filled in by

Baltimore, Maryland 21215-0036

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Ki chard l'almer State

29a. Certifier

(Check only one) 29b. Signature and title

Medical

31. Date liled (Month, Day, Year) 2006



MI

Registrar

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1)0055120

Juk 310 Washingha

29d. Date signed (Month, Day, Year)

2006

Please Type or Print in Black Indelible Ink

Rami Vincente-R	1	- For State	State of	Maryland		rtment of fificate of	Health and Death	d Menta	al Hygie		2. No. 2	006	2081	
Physicia Medical Examir	n/	Registrar 1. Decedent's Name (First, I Ramiro		Vicent	:e	Rome	ro		- М	ate of Death	Day Year		e of Death 45 hrs	
		4a. Facility Name (if not inst University Hospita		reet and numbe	er)		b. City, Town, or Baltimore	Location of	Death		4c. County of [)eath		
Funeral Director		5. Social Security Number none	6. Sex	7. A	Age (In yrs. Ias	st birthday) Yrs	If Under 1 Yea Months Day				/1987		(State or emala	
d now any		Usual Residence of Decede 10a. State		n	10c. City, 7	Town or Locati	on						rside City Limits Yes 2 X No	
death with the Maryland or items 23a or 28a-f show any must he notified at once	Director	10e. Street and Number 231 North	Piedm	ont St	reet	-	10f. Zip Code 222					Country? emala	,	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner.	by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4	Married 1	Dates:	es? 2 X No	1 X	s Decedent of His es, specify Cubar Yes 2 No	n, Mexican, F Guate specify:	Puerto Rica Smala	n, etc.) an	White, e	Wl	nite	
5-0036 iled within 72 hours Hygiene. I other than "natur Ib Medical Exam	Completed I	15. Decedent's Education Elementary/Secondary (1 1 2	1-12)	College (1-4 o		during m	t's Usual Occupa ost of working life borer	. DO NOT u	se retired)		16b. Kind of Busir			
215-C be filed v nntal Hygi rked oth	Be	17. Father's Name (First, M Jose Vicer	te Lu					Jua	na R	omer	daiden Surname) O Corte			
MD 21 d 2 should I th and Mer n 27 is man	1	19a. Informant's Name/Rela Gregorio V				231	North	Pied	lmont	Str	ber, City or Town, et Arl 20c. Location - C	ingto	n, Va	
Baltimore, permit. Pages I an Department of Hea Important: If iter		20a. Method of Disposition 1 X Burial 2 Crer 4 Dopation 5 Ott 21. Si of Funeral	Specify:		State C	emeter San		icipa	6/21	/06	San Jua Guate	an Os emala	tuncalc	
	17	July Bu	wille	-4	ed the death.	192	41 Coli	umbia	Blv	d.Si	RAL SER' Lver Sp: est, shock, or heart	ring.	P.A. Md20910 roximate Interval ween Onset and	
Physician /Medical Examiner														
	caminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
O, e be executed ysician and burial - transit	edical Exa	UNPENDED	d,	AMENDED										
Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu	sician/Me	IF FEMALE: 23b. Was decedent pregnal past 12 months? 1 Yes 2 No 9	, ,1	23c. If yes, out 1 Live birth 4 Pregnant 9 Unknowr	n t at time of dea	2 Fe	etal death 3 ther (Specify)	Ectopic	pregnancy		23d. Date of de Month	elivery Day	Year	
P.O. Erres that the consigned by the detached	d by Phys	Part II. Other significant o	onditions co	ontributing to de	eath but not re	esulting in the	underlying cause	given in Par	t I.		obacco use contribu			
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the safter death. al Director. After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed									1 Yes	sy pri- rmed? de		indings available tion of cause of	
Vital ysician: his certif	To Be	25. Was case referred to n examiner? 1 ✓ Yes 2 N	Hos	spital: 1 Inp	atient 2	ER/Outpatien		Other4	Check only Nursing Ho		Residence 6	Other:		
on of ' ending Ph ath. or: After t	tion: T	27. Manner of Death 1 Natural 5	Pending Investigation	28a. Date of (Month, Di Jun 8, 200	Injury ay,Year) 6	28b. Time of 1830 hrs	· · I _ ·	ury at Work? Yes 2 ✔	Isul		now injury occurred senger in vehi		on	
Divisior Hospital or Attend 24 hours after death Franceal Director: stely filled in by the	Certification:	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. Place o		ome, farm, stre d / Highway	et, factory, office	building, etc		or Town, S	Street and Number state) ds 353 & 369,			
To the Host within 24 ho	Medical C	29a. Certifier 1 Certify one) 2 Medic	I Examiner: 0	n: To the best of on the basis of on ond manner stat	examination a	ge, death occu nd/or investiga	rred at the time, o tion, in my opinio	date and place n, death occ	ce, and due curred at the	to the caus e time, date	e(s) and manner a and place, and du	s started. e to the caus	e(s)	
3	Me	29b. Signature and title of		N	1		29c. Licen	se number			June 14, 200	,	ıy, Year)	
		30. Name and address of Susan Hogan MI		mpleted cause ant Medical			nn Street, Ba	Itimore, M	1D 21201	1				
S Regis	tate trar	97 170	Year) 6 20		strar's Signatu	B. As	artis)							

		1	For State Registrer	State of Maryland		rtment of H		Re	ag. No.	16 20845
	Physicia	an	1. Decedent's Name (First, Middle, Last) Nell Louise RUMAGE					2. Date of Deat Month June		3. Time of Death 4:25pm M
	/Medic Examin		4a. Facility Name (If not institution, give st Ravenwood Lutheran			4b. City, Town, or Hagerst		ıth	4c. County o Washin	
	Funeral Director		1/7-05-2848	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Year)	9. Birthplace (State or Foreign Country) Pennsylvania
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Washing		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
	with the	Direc	10e. Street and Number 1183 Luther Drive			10f. Zip Code	21740	1	0g. Citizen of WI	hat Country?
36	i 72 hours after death with the Maryland "netural", or Items 23a or 28a-f show after Francinal be neithed at	by Funeral Director		2. Was Decedent Ever in U.S Armed Forces? 1		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (In, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race Black	- American Indian, t, White, etc. white
21215-0036	- ×	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired	during most of w		16b. Kind of Bus	
	be filed ital Hygi od other event, I	Be	12 17. Father's Name (First, Middle, Last) Hamilton Clemow	0	se	curity g	18. Mother's N	ame (First, Middle,) 7 Winters		tment store
Maryland	s 1 and 2 should it Health and Men item 27 is marke other traumatic.	T ₀	19a. Informant's Name/Relationship (Typ				and Number or I	Rural Route Number		
	of Health of Health item 27 i		Maryellen Kish - d			Upper Ringlesition (Name of matory or other place		, Pennsbu		18073 City or Town, State
mor	Pages nent of int: If it		12 Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State		matory or other place m Mem. Pa		/22/06	Hagers	town, Maryland
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.	8 1	21. Signature of Eugeral Service License	Tkener (41	L5 E. Wil	son Blvo	MINNICH FULL., Hagers	stown, M	
	Fnysician /Medical Examiner		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that caused the death e cause on each line. Due to (or as a consequence)	uence off:				est,	Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequence of the second of	uenc of):	dear	+ Fa	Silver		
8760,	cate be executed by sician and the burial-transit	ical	resulting in death) Last	Due to (or as a consequence of the consequence)	uence of):	spriefrie	pula	way	disease	
.O. Box 6	ath certific attending p for use as	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	ac. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date Mon	e of delivery hth Day Year
Δ.	wrequires that the debeen signed by the should be detached	by	Part II. Other significant conditions con Plen with	tributing to death but not res	ulting in the u	undertying cause gru	ven in Part I.			ibute to the cause of death? 3 Unknown
Records,	blas has	Completed	Reval ins	uffici ener	7			24a. Was a autop perfor	sy p med? d	Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 [8 40
of Vital	sician: certific rector,	o Be (25. Was case referred to medical examiner?	ospital:	ER/Outpatie	nt 3□ DOA Oth	or /	eath (Check only of Home 5 Resid		er (Specify)
ion of	ding After fune	H	27. Manner of Death 1 (D) Vatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c, Inju	rv at		ow injury occurre	
Division	Dire Dire	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, si	treet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,
	Hospitel 24 hours a Funerel	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, dea ation and/or i	th occurred at the tinvestigation, in my	me, date and pla opinion, death o	ace, and due to the occurred at the time, o	cause(s) and mai date and place, a	nner as stated. and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		10	29c. Licen	se number	-		(Month, Day, Year)
			30. Name and address of person who co	empleted sause of death (Iter	n 23a) (Type	, Print)	-0-[11		June	ersfour MD
0	5H-2		JERRY L	COFFE CE	5,0	n-D. It	24 Of	al Couf	1 4299	ersfour MD
:	. Si	trar	31. Date filed (Month, Day, Year)		A.	houses	-		•	nato

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 2:05 PM 13 2006 June Rowan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Arbor at Baywoods Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year)
Aug. 24,1917 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral ™** 2□ F 88 Texas Director 462-10-2156 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or iteme 23a or 28a-f ehow Examiner must be notified at Jefferson Metairie 1 ☐ Yes 2X No LA Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 70005 800 Rue Ramport #230 USA deeth by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 100 Urger 1 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 end 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify White 3 Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Engineer Petroleum 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Spencer F. Rowan Sue O. Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If Item 27 i Jane S. Rowan (Wife) 800 Rue Rampart #230, Metairie, LA 70005 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any Injury or once. Forest Park Cemetery 6-17-2006 4 ☐Donation 5 ☐ Other (Specify) Houston, TX 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Dalad 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Anemia levere /Medical Due to (or as a consequence of): Examiner Diseases hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine TOPD or Attending Physician: The law requires thet the death certificate be executed 9 months ongestive heart g physicien and as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 3 Probably icete hes been sig 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24a. Was an autopsy performed.
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Assisted Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending s efter death.
I Director: Aft
id in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral I Hospital peliil Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ٥ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0062705 30. Name and address of person who completed cause of deaf (Item 23a) (Type, Print) 116 Defense Hwy, Suite 400, Annapolis, MD 21401 Mundorf ucinda 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature State 2006 Registrar 15

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar			d / Depa		Health and N	Mental Hyg	iene	16	208	347			
			Registrar Decedent's Name (First, Middle, La	(st)		Cei	uncate of	Dealli	2. Date of Deat	g. No.		3. Time of	l Death			
	Physici			,	2.37				June 17,	2006	/ear	:10	р м			
	/Medic Examin		RITA ALMA S 4a. Facility Name (If not institution, given	SLATTER			4b. City, Town, o	or Location of Death		4c. County of			P			
	Lxuiiii		Civista Medical (LaPlata	, MD		Charle	es					
180	Funeral			Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9. Birthplac	ce (State o	or Foreign			
	Director		5/8-34-/602	1□M 2∏F	88	Yrs.	Months Days	110010	NOV.11		IARY					
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				100	d. Inside C	ity Limits			
,	Maryl f ehc	ō	MARYLAND CHARI	TES		Τ. Δ. Ι	PLATA					1.□Yes	2 🗆 No			
1	7.288	rec	10e. Street and Number	1110		DF1 1	10f. Zip Code		10	ng. Citizen of Wh	at Country					
2	h witi	E O	121 MORRIS DRIV	ΙE			206	46		Ţ	J.S.	Α.				
-,}	-me	ner	11. Marital Status	12. Was Dec	edent Ever in U.	.S. 13. \	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No-	14. Race -	American White, etc					
I se	s afte	y Fu	1 Never Married 2 Marned	1 ☐ Yes If Yes, Gir	2∕∰ 0∘ ve		1 □ Yes XXNo			Specify:						
164	IZ I 3-UU30 within 72 hours after death with the Maryland ane. sne. then 'natural', or iteme 23e or 28e-f ehow item Marifeal Exercise the marifeal at	Be Completed by Funeral Director	3√√Vidowed 4 □ Divorced 15. Decedent's E	Year or D	ates:	16a Decer	dent's Usual Occur	nation		6b. Kind of Busi		ITE				
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/ 5		EO	Elementary/Secondary (0-12)	College (1-40r 5+)	SECRI	ETARY			NATION? FEDERAT		TLDL	1 F E			
	0 > = =	3e C	17. Father's Name (First, Middle, Last	')				18. Mother's Nam	e (First, Middle, N	faiden Sumame)						
A. 6	should be nd Mental marked o	2	HARRY C. SWAND	1				MARGARE	T DYSO	N						
ع ر	Maryland d 2 should be file th and Mental H; it is marked oth traumatic even	1	19a. Informant's Name/Relationship		~ ~ ~ ~			and Number or Rur								
U	C = 44 +		JOHN F . SLATTE	ERY,JR.			/ KLINE	DRIVE, I	_	A,MARYI 20c. Location - C			46			
0		1 3	Burial 2 ☐ Cremation 3 [Removal from	State	emetery, cren	natory or other pla	ce)								
V	Dailing permit. Page Department of Importent: If eny injury or		4 Donation 5 Other (Speci 21. Signature of Funeral Service Lice			-	S CH.	CEM . 6-2	22-06	BRYANTO	MILL	MARY	LAND			
	Depa Impo		174.7. 5	20.	MOU	I	RAYMOND	FUNERAL			•					
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that	caused the deat	h. Do not ent	er the mode of dyn	A, MARYI ng, such as cardiac	AND 200 or respiratory arre	546	A	Approximat	te			
	Physician	8 //	Immediate Cause (Final disease or condition	P	1			lizm			Ö	nset and	Death			
	/Medical		resulting in death)	aDue to	(or as a conseq	uence of.	LMD	nin								
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¥	be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence ol);					-					
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	BOX eath cert attending for use	an/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pregnanc	v		23d. Date			3			
	o deal	by Physician/Med	in the past 12 months?		nant at time of d		Other (specify)			Month	h Da	ay '	Year			
2	nat the d d by the letached	Phy	9 ☐ Unknown Part II. Other significant conditions			ulting in the	adarkijas savas -u	one in Don't	220 Did tob	acco use contrib			44-2			
1	OT VICAL MECOLOS, Physician: The law requires the this certificate has been signeral director, page 2 should be great		Part II. Other significant conditions	contributing to a	eath but not res	unting in the u	ndenying cause giv	ven in Part I.								
	request shoulk	etec	1 Yes A No 3 Probably													
Š	he fav	Completed							24a. Was ar autopsy perform	/ prid	ere autops or to comp ath?	y lindings pletion of c	available ause of			
9	in: Ti		25. Was case referred to medical					00 PlI P	1□ Yes 2	2 № 1 [Yes 2	□ No				
	ysicie is cert direct	To Be	examiner?	Hospital:	Inpatient 2	ER/Outpatien	nt 3 DOA Ott	200	th <i>(Check only one</i> ome 5 🗆 Reside		(Specify)					
	ng Ph ter th		27. Manner of Death	28a. Date (Mon	of Injury oth, Day Year)	28b. Time of Injury	f 28c. Inju- Wo		28d. Describe ho							
	SIOI eath. or: Al	catic	2 Accident investigate 3 Suicide 6 Could not i	20			M 1	Yes 2□No								
	LIVISION I or Attending after death. Director: After	Certification:	3 Suicide 6 Could not t 4 Homicide determined	200. Place	ol Injury - At he ling, etc. (Specif	ome, farm, str y)	eet, factory, office		28l. Location (Str City or Town		or Rural F	₹oute Nun	nber,			
	pital purs a cerail	S	29a. Certifier Certifying P	hysician: To the	a hest of my kno	wiedge deati	h occurred at the tr	me, date and place,	and due to the en	usp(a) and wises						
-	DIVISION Of VITAL RECORDS, P.O. BOX 58 To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as in	edical	(Check only 2 Medical Exa	miner: On the b	pasis of examina ner stated.	ition and/or in	vestigation, in my	me, date and place, opinion, death occur	red at the time, da	ite and place, an	d due to th	ed. 10 causo(s	5)			
	To th within To th compl	Me	29b. Signature and title of certifier	1			29c. Licens	se number	29	d. Date signed (Month, Da	ıy, Year)				
	-		+ tames	y - Ha	ning		D-52	2919		6/18/	06					
-	10		30. Name and address of person who	completed cau	se of death inten					1 /						
	12		James I. Harring	, MD, 1	02 Cent	ennial	St., Ste	e. 102, La	aPlata, N	1D 2064	6					
	Sta Regist	ate rar	31. Date liled (Month, Day, Year) JUL 3 - 2	006	egistrar's Signa	8 4	and I					*				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Jun 25, 2006 **Physician** 8:29 pm^м Shircliff Donaldlyn Mae /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cumberland Allegany 611 Brookfield Avenue Apt. 3 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Wooths | Days | Hours | Min. | Way 1, 1926 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 80 Yrs. 220-16-6828 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthan "natural, or itama 23a or 28a-f ahov tra Madical Examinar must be notified at Cumberland Allegany MD 1 □X(es 2 □ No Be Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21502 611 Brookfield Avenue Apt. 3 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itan any injury or other traumatic ayant, Ita Medical Experiment once. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Faculty Secretary Allegany College 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sylvia Elizabeth (Godwin) Hinze H. Franklin Hinze ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5609 Westgate Shawnee KS 19a. Informant's Name/Relationship (Type, Print)
Dena Scrivani 66216 daughter 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Hillcrest Memorial Park 6/29/2006 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Sorvice Licenses 22. Nam Scarbein Pune P.A. 108 Virginia Avenue; Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Chronic Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death | Check only one Be Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 5 Residence 6 Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident of the death of th filled in by the 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital o within 24 hours ef To the Funeral Di Decrtiffing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner scated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 27, 2006 D36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924 Seton Drive Cumberland MD 21502 Vikramaditya Poonai M.D. 31. Date filed (Month, Day, Year) State Registrar 3 - 2006

			For Stata Registrar		State of	of Mar	yland				ealth a		lental Hy	giene	200) 6	208	49
	Dhusisi		Decedent's Name (First, Mide	fle, Last)				-					2. Date of De Month	Day	,	Year	3. Time of	Death
	Physici /Medic		Paul F	Sm		Jr			,				June	2	<u>0</u> 2	006	8:53	AM
	Examin	er	4a. Facility Name (If not instituti		A 4.				,		Location			1 -1	County o	of Death		
٠			5. Social Security Number	6. Sex		chica	In yrs. las			I Thn or 1 Year	1010	24 Hrs	8. Date of Bir	n/	d	O Biebal	(Ctato -	. Foreign
	Funeral Director		218-88-1092		M 2□F	29		Yrs.	Months		Hours	Min.	Dec 8,	³ 197	3	Count	ace (State o.	roreign
			Usual Residence of Decedent										2000,					
	rylan	_	MD 10b. Coun	y gany	,	11	0c. City, T		ocation Derlar	nd						10	od. Inside Cit	-
	Sa-f.e	cto		gany				Curric									1)(] Yes	2 No
	within 72 hours attar daath with the Maryland ane. than "natural", or Iteme 23a or 28a-f ehow he Madical Examinat must be rightled at	by Funeral Director	10e. Street and Number 95 W. Oldtown	Pos	d				10f. Zi	p Code	21502)		10g. Citi	zen of W	hat Count	try?	
	ne 23	eral	11. Marital Status		12. Was Dec	edent Fve	er in II.S	13.	Was Dece				acify Yes or No	\- \		- America	an Indian	
٠.	ttar d	Ē	1 Never Married 2 ☐ Ma	i	Armed Fo	orces?	31 117 0.0.			V	n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)			c, White, e		
93	al', o	ρ	3 Widowed 4 Divorce	1	1 □Yes If Yes, Gi Year or D	Dates:			1 🗆 Yes	21 No	Specify:				Specify:	white)	
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22	ljed v Tygia Ther ti	ပိ	12 17. Father's Name (First, Middle	2 / act)			r	oofe			18 Mothe	ar's Name	e (First, Middle			Comp	ally	
and	d ba f) Be	Paul F. Smit										ne D. (S				ite	
Maryland 21215-0036	shoul nd Me mark	٦	19a. Informant's Name/Relation		pe, Print)			19b. Maili	ng Addres	s (Street a	and Numbe	er or Rura	al Route Numb	er, City o	r Town, S	State, Zip	Code)	
ž	alth a 127 is		Paul Smith Sr.		fa	ther		4108	B Cos	eyto	wn Ro	oad	Gree	ncasi	le	PA	1722	5
ore,	of Herrican		20a. Method of Disposition 1 Burial 2 Cremation	م ال	amoval from	Ctata	cem	etery, cre.	osition (Na matory or	other plac	e)		Date			City or Tov		
Ĕ	Pag mant ant: h		4 Donation 5 Other		emovar nom	State	Sunse	et Men	norial	Park	ļ		6/30/2006	Cui	mber	rland	М	D
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural; or iteme 23a or 28a-1 show appring to other traumatic event, the Macical Examinat must be rolling at ODCe.		21. Signature of Funeral Service	e License	** \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1.00	M-	2:					me, PA					
_	462 6 4		23a, Part . Enter the disease,	or compli	cations that	caused th	e death	Do not en					: Cumbei		MD 2	1502	Approximate	
			shock, or heart failure. Li Immediate Cause (Final	t only on	ne cause on	each line.						0274.20		11031,			Interval Bety Onset and D	Neen
	Physician /Medical		disease or condition resulting in death)	_ a	HOC	JOK1	NS.	Lyr	ubur	mo	<u> </u>							
	Examiner					(0, 23 2 0	onsoquoi	100 017.										
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×	certifi ding usa as	/Me	IF FEMALE: 23b. Was decedent pregnant	2	3c. If yes, ou	itcome of	pregnancy	y							P3d Date	of deliver	2/	
Вох	daath a atter d for u	clar	in the past 12 months?		4☐Pregi	birth 2 [nant at tim			⊒Ectopic p ⊒ Other (s						Mon		,	'ear
P.O.	t tha by the tache	Physician/Med	9 Unknowh	-	9□ Unkn	own												
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ord	w raquire been sij should t		ļ . —										10	Yes 2	□No :	3 ☐ Proba	ibly 4 🕦	nknown
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Ž	siclar cartifi ractor	Be	25. Was case referred to medic examiner?		lospital:					Oth e			Check only		_			
ō	Phys r this rral di	. To	1 ☐ Yes 2 No 27. Manner of Death	1	28a. Date	Inpatient of Injury	28	VOutpatie		OA 28c. Injury Work	4 🗆 140		me 5 Resi)	
on	Attending ir daath. ector: Attai	ş	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ling tigation	(Mon	nth, Day Y	ear)	Injury	М		(? Yes 2 ☐	No						
Division of Vital Records,	ar dag ector by th	Certification;	3 ☐ Suicide 6 ☐ Coul	d not be mined	28e. Place	e of Injury ling, etc. (- At home	e, farm, st	reet, facto	y, office			28f. Location (City or To	Street and	d Numbe	r or Rural	Route Numb	oer,
	tal or rs atta ral Dir	Cert	4 Tiemode		Dulid	iing, otc. (apacity)						Ony of 10	wii, State,				
	Hospital 24 hours a Funeral I taly filled	edical	(Check only 2 Medica	ing Phys il Examii	ner: On the b	pasis of ex	amination	edge, deat and/or in	h occurred vestigation	d at the time n, in my op	e, date an pinion, dea	id place, ith occurr	and due to the ed at the time,	cause(s) date and	and man place, ar	ner as sta	ited. the cause(s)	
	To the Hospital or Attending Physiclan: Tha lav within 24 hours after death. To the Funeral Director: Atter this cartificate hes completely filled in by the funeral director, page 2	Med	one) 29b. Signature and title of certifications	ier	anu man	ner stated	J.		29	c. License	number			29d. Dat	e signed	(Month, D	Pay, Year)	
	⊢s⊢ŏ		Doch a	81	ulu	_	NAC)		PI	355	0			ne :			
			30. Name and address of person			se of deat	th (Item 23		Print)	, ,				Jul	10	20	2006	2
70	_1_		Rachel Sa	lit	22	LS.	Gre	ene	St	BO	Ihn	nuve	, MD	2	120			
	Sta		31. Date filed (Month, Day, Xea	2006	32. F	Registrar's	Signature	Cas	20				,					
	Registr	al	002.0		1		•											

		1	For State Registrar	State of Ma		artment of F		lental Hygier	Z (HU)	20850
A	fix.		1. Decedent's Name (First, Middle	, Last)				2. Date of Death Month	Dav Year	3. Time of Death
Total	Physicia /Medic		Augusta	L. Swee	t			June 15	2006 ^{Year}	0120 м
	Examin		la. Facility Name (If not institution				r Location of Death		4c. County of Death	
		3	Montgomery			Olney		O Data of Birth	Montg	
	Funeral	===	5. Social Security Number 059-16-4812		(In yrs. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea	ar) Cou	place (State or Foreign intry)
	Director	-	Usual Residence of Decedent					2/15/19	I/ New	York
	iand ow	. H	10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits
	Mary	tor	MD Mont	gomery	Sandy	Springs	5			1 ☐ Yes 2 🖾 No
	h the	lred	10e. Street and Number			10f. Zip Code	2000	10g.	Citizen of What Cou	intry?
	th wil	al	17340 Quaker	Lane			0860			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f ehow important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f ehow propriety in your or other traumatic event, Ital Mudical Examinat must be notified at announce.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marr 3 ☑ Widowed 4 □ Divorced	If Yes Give	iver in U.S. 13	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛛 No		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
ğ	2 hou	ted	15. Deceden	it's Education	16a. Dec	edent's Usual Occup e kind of work done	pation	ing 16b	Kind of Business/l	ndustry
21215-0036	thin 7 8. n. n.	ple	Elementary/Secondary (0-12)	college (1-4or 5-	life	retary/(d)		Educat	ion
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nd	be fill d oth	Be	17. Father's Name (First, Middle,					e (First, Middle, Maid tte Pepp		
<u>\frac{2}{3}</u>	12 should be filed within h and Mental Hygiene. 7 is marked other than "I raumatic event, I'm Mel.	ဥ	William Ferr		10b Mai	ling Addross (Street		ral Route Number, Cit		in Code)
Maryland	12 sh h and 7 is n traun		19a. Informant's Name/Relations			West R			dis, N.C	
e,	Healt Healt em 2	-	C.William Fr	ench/son	20b Place of Dist	osition (Name of			Location - City or	
Baltimore,	Tr. # It		1 ⊠Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		On onda o	ematory or other pla	v Cem 6/	20/06 5	vracuse	,New York
틀	artme brtan injur		21. Signature of Funeral Service	/ /				FUNERAL		
Ba	Ped dimi		> Mules De	molle						g,Md20910
	*		23a. Part1. Enter the disease, or	r complications that caused tonly one cause on each lin	the death. Do not e	nter the mode of dyi	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			41,,,,,				Onset and Death
	/Medical		resulting in death)	a. Respir Due to (or as	atory Fa	TTure				
35.	Examiner		Sequentially list conditions,	b. Aspira	tion Pne	umonia				
190	p #	ner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of).					
	and trans	Examiner	that initiated events resulting in death) Last	c.	a consequence of):					
8760,	death certificate be executed e attending physicien and of for use as the buriat-transit	al E	,	550 15 (5) 45	a sonsoquonos si,					
87	physis the b	edical		d						
9 X	eath certific attending p for use as 1	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of deli	very
Вох	atter atter for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at		□Ectopic pregnanc □ Other (specify) _	у		Month	Day Year
o.	t the de by the tached	hysi	9 Unknown	9□ Unknown						
Д,	tha de	by PI	Part II. Other significant conditi	ons contributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.	23e. Did tobace	co use contribute to	the cause of death?
rds	w requires been sign should be							1 🗆 Yes	2 □ No 3 □ Pro	obably 4 🗖 Unknown
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Ĕ	The late a	Eo						performed 1 ☐ Yes 2 🔀	? death?	2 No
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of V	Physician: this certific ral director,	2	1 ☐ Yes 2 🙀 No		nt 2 ER/Outpat	BIL 30 DOA		ome 5 Residence		city)
		on:	27. Manner of Death 1 ★Natural 5 ☐ Pendi		ry 28b. Time y Year) Injury	/ Wo	ork?]Yes 2 □No	28d. Describe how i	njury occurrea	
sio	en eatl ber: he	cat	2 Accident invest 3 Suicide 6 Could	I not be as Blace of Ini	ury - At home, farm,			28f. Location (Stree	t and Number or Ru	ral Boute Number
Division	7 4 5	Certification:	4 Homicide determination	mined 288. Flace of 11) building, et		street, ractory, office		City or Town, S		
_	To the Hospital of Within 24 hours af To the Funeral D completely filled in		29a. Certifier 1 X Certifyi	ing Physician: To the best	of my knowledge, de	ath occurred at the t	me, date and place	, and due to the caus	e(s) and manner as	stated.
	To the Hospital within 24 hours of To the Funeral completely filled	edical	(Check only 2 Medical one)	Examiner: On the basis of and manner sta	f examination and/or	investigation, in my	opinion, death occu	rred at the time, date	and place, and due	to the cause(s)
	Fo thi Nithin Fo the	∑ E	29b. Signature and title of certific	er			se number		Date signed (Monti	
						D0	061681	J	une 16,2	006
•	1> (30. Name and address of person	n who completed cause of c						
			Kirkaldy, I				nce Phi	lip Dr. (Olney,Md	20832
	St Regist	ate trar	31. Date filed (Month, Day, Year JUN 1	9 2006 32. Augistr	ar's Signature	docke.				

		-	For State Registrar		State of	Marylan		ırtmeni <i>tificate</i>			and Me		giene Reg. No.	2006	20	851
	Physicia		Decedent's Name (Final Audre) Audre		M.		Sansbur	y				2. Date of De Month	Day	Year	3. Time of 9:27	
	/Medic Examin		4a. Facility Name (If not		ve street and num	ber)		4b. City,	Town, or	Location o	of Death	June 14	4c. C	County of Death	1	Γ
			5108 Hagan					Temp If Under	le Hi	11s If Under 3	24 Hrs 1	0.0(8:		nce Geor		
	Funeral Director		5. Social Security Numb 579–32–1953		Sex 1□M XXX F	. Age (In yrs. I	Yrs.	Months	Days	Hours	Min. I	8. Date of Bird C. 14,	¹⁹ 1924		place (State o intry) ington	
	and w		Usual Residence of Dec	cedent b. County		10c. City	y, Town or Lo	cation							10d. Inside C	
	the Marylar 28a-1 show	tor	Maryland	Prince (George's		Temple	Hills							1 🗌 Yes	3√√ No
	th with the 23a or 28s	ai Direc	10e. Street and Number 5108 Hagan					10f. Zip 20	^{Code} 748					en of What Co ISA	ıntry?	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menall Hygiene. Department of Health and Menall Hygiene. In proprient: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 3XX Widowed 4 ☐		12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Da	ces? ZXXNo		Vas Deced f Yes, spec			gin? (Spec I, Puerto F	cify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify: Wh		
21215-0036	rithin 72 ho ne. han "natur e Medicsi	mpieted	(Specify of Elementary/Secondary		Education rade completed) College (1-	4or 5+)	life. I	kind of wor DO NOT us	rk done d se retired)	urina most	t of workin	g		d of Business/I		
and 2	d be filed v ental Hygie ced othar t c avant, In	To Be Co	12 17. Father's Name (Firs Frank		it)		Su	pervis	or		_	(First, Middle, 1rence		ral Gove	rnment	
Maryland	d 2 shoul th and Me 7 is marl traumati	Ĕ	19a. Informant's Name Deborah Shuck									Route Number		Town, State, Z 20602	ip Code)	
Baltimore,	Pages 1 an ient of Heali nt: If itam 2 iry or othar		20a. Method of Disposit	tion remation 3	☐Removal from S	C	lace of Dispo emetery, crem Olivet	sition (Nan	ne of	a)	Da	, 2006	20c. Loc	ation - City or I		
Balti	permit. Departm Importe any inju		21. Signature of Funera	al Service Lice	ensee	6						ge P. Ka on Hill,		ineral Ho and 20	ne PA 745	
	Physician /Medical		23a. Part. Enter the d shock, or heart fa Immediate Cause (Final disease or condition resulting in death)	ilure. Eist ont	a	ch line.	Car	er the mod	e of dying	g, such as	cardiac or	respiratory a	rrest,		Approximat Interval Bet Onset and I	ween
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8760,	aath certificate be executed attending physician and for use as the burial-transit	dicai Examiner	Cause (Disease or inju that initiated events resulting in death) Last	_	c. Due to (c	or as a consequ	uence of):									
O. Box 6	o o	Physician/Medi	IF FEMALE: 23b. Was decedent pre in the past 12 moi 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	nths?		rth 2 ☐ Fetai int at time of d	Ideath 3	Ectopic pr Other (sp					23	3d. Date of deli Month	-	Year
۵	es gu	by	Part II. Other significat	nt conditions	contributing to de	ath but not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did t		e contribute to	the cause of cobably 4 🗆	
Division of Vital Records,	The law ate has b	Completed	5 - 22									24a. Was autor perfo 1 🗆 Yes	psy prmed?	24b. Were au prior to o death? 1 \(\sum \) Yes	ompletion of c	available ause of
Vita	Physician: Th this certificate al director, pag	Be	25. Was case referred examiner?	to medical	Hospital:				Othe	·C		(Check only o				
n of	Phys r this ral dii	on: To	1 Yes 2 XXVo 27. Manner of Death XX Natural 5	5 ☐ Pending	28a. Date o	_	28b. Time of Injury		8c. Injury Work	at	2	8d. Describe		Other (Spec	ify)	
Divisio		Certification:	2 Accident	investigati Could not determine	ho -	of Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, str	M eet, factory		∕es 2□		8f. Location (: City or To	Street and wn, State)	Number or Ru	ral Route Num	ber,
_	To the Hospital or Attan within 24 hours after deat to the Funaral Director: completely filled in by the	edical C			Physicien: To the aminer: On the ba and mann	sis of examina)
	To the complex	Me	29b. Signature and title	of certifier	MD)			License	number	190	79	29d. Date	signed (Month	Day, Year)	
2	(29)		30. Name and address	of person wh		of death (Item 1637 Tem		Print)					0602	•		
	Sta		31. Date filed (Month, I	Day, Year)		ngistrar's Signa			US N	aluori	, rei	улани Z	.0002			
	Regist	ar	JUN	1 9 201	00	HU JE	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day}2006 4:15P June 16, L. Singletary, Sr. Henry 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days 1□M 2XF North Carolina 4, Jan. Yrs. 1941 578-56-2058 Usual Residence of Decedent 10d. fnside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No Maryland Prince George Fort Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Stonesboro Road 20744 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Maritaf Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coffege (1-4or 5+) National Park Service Maintenance Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Albert Sidney Ezra Singletary Loucile Powe11

with the Maryland f Health and Mental Hygiene. Itam 27 is marked other then "naturel", or Itams 23s or 28s-1 show other traumetic event, the Modical Examiner must be notified at permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene
Important: If Itam 27 is marked other then "naturel", or Itams 23a
any Injury or other traumetic event, the Modical Examiner research Baltimore, Maryland 21215-0036

1 - For State Ragistrar

10a. State

3744

by Funeral Director

Be Completed

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner

The law requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital

Physician/Medical Examiner attending physicien and for use as the burial-transit signed by the a þ Completed page 2 To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certificel completely filled in by the funeral director, p. Be ٩ Certification:

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. fnformant's Name/Relationship (Type, Print) Jean K. Singletary/Wife 3744 Stonesboro Road Ft. Washington, MD. 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Resurrection Cemetery 6/22/06 Clinton, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Geo. P. Kalas Funeral Home 21. Signature of Funeral Service Licensee 5160 Oxon Hill Rd. Oxon Hill, Md.20745 also 23a. Part. Enter the disease, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Severe Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>Endocarditis</u> Due to (or as a consequence of) IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 🖾 Natural 1 ☐ Yes 2 ☐ No M 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and ti DR63579 June 16, 2006

Registrar DHMH 17 Rev 1/2001

State

Maria Tayag, M.D. 1500 Forest Glen Rd. Silver Spring, Md. 20910

32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUN 1 9 2006

		1	State of Maryland / Dep State of Maryland / Dep	artment of Health and M <i>rtificate of Death</i>	lental Hygiei Reg.	_	20853				
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death				
	Physicia		Ella C. Shannon		June 18,	-	8:40 A ^M				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death					
		и	2942 Rosemar Dr.	Ellicott City		Howard					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	Month, Day, Year) Country)					
	Director		136 20 5466 92		6/12/1914	New .	Jersey				
	pus *	l	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits				
	Aaryla I sho	ō	MD Howard Elli	cott City			1 ☐ Yes 2 No				
	the A	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?				
	with Mith	٥	9905 Lamott Ct.	21042		USA					
	ter death Items 2: Iner mus	Funeral		Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri Black, White,					
က္	or Ite	Fur	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 ☒ No Specify:	rricari, etc.)						
03	72 hours after death with the Maryland naturel; or Items 23e or 28e-f show Jisal Evandrer must be notified at	l by	3 Nidowed 4 □ Divorced Year or Dates:	TE 163 ZELITO Specify.		711.	ite 				
215-0036	72 h	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of work	ing 16b	. Kind of Business/In	dustry				
21	vithin ne. hen	ldm	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)							
121	filed within Hygiene. other then "		17. Father's Name (First, Middle, Last)	ncipal 18. Mother's Name	e (First, Middle, Maid	Education					
Maryland	d tal	m	Bartley Bartholemew Cruise		Veronica						
Z	should ind Men s marke umatic	2		ing Address (Street and Number or Rura			o Code)				
Ma	and 2 sauth ar n 27 is		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Lamott Ct. Ellic	ott City,	MD 2104	2				
ē,	ss 1 and 3 of Health Item 27		20a. Method of Disposition 20b. Place of Disposition cametary, cre	osition (Name of amatory or other place)	Date 20c	. Location - City or T	own, State				
a B			1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Cr		2006 Ca	tonsville	MD				
altimore,	# E E E			2. Name and Address of Facility Har							
m	Deparelling once		Verni L. Kudde 4	112 Old Columbia P	k. Ellic	ott City,	MD 21043				
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between				
	Physician		Immediate Cause (Final disease or condition	Alzheimers			Onset and Death				
	/Medical		resulting in death) Due to (or as a consequence of):								
П	Examiner		Sequentially list conditions, bb.								
	be sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
	and I-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):								
8760,	cate be executed oblysician and the burial-transit	a E									
687	ficate phys s the	by Physician/Medical	d								
Вох (certifica nding ph use as t	/M	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	rery				
B	w requires that the death certific been signed by the attending p should be detached for use as	icia	in the past 12 months? 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year				
0	t the by the	hys	9 ☐ Unknown								
O.	requires that the een signed by th nould be detache	oy P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to	_				
ırd	aquire en siç ould b				1 🗆 Yes	2 No 3 Pro	bably 4 Gunknown				
Vital Records,	e law re has be je 2 shi	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of				
<u> </u>	Th ate pag	Con			performed 1 ☐ Yes 2 🔀		2 No				
/ita	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		h (Check only one)	-,					
of \	S S	은	1 Pes 2 No Hospital: 1 Inpatient 2 ER/Outpatie		ome 5 Residence		Asst. Lvg.				
n c		lon:	27. Manner of Death 1 ▼Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 1 Injury 28b. Time Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe now	injury occurred					
Sio		icat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury At home farms		28f. Location (Stree	t and Number or Rur	al Route Number.				
Division of	or At after of Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	niest, tationy, onlise	City or Town, S	îtate)					
	ospital hours a unerel E	S S	29a. Certifier Certifying Physicien: To the best of my knowledge, dea	ath occurred at the time, date and place,	and due to the caus	e(s) and manner as	stated.				
	工 4 正 5	edical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, date	and place, and due	to the cause(s)				
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)				
)			MO MO	DS874	J L	one 19	2006				
ه (ند	2		30. Name and address of person who completed cause of death (Item 23a) (Type		0 1) 0				
<u>"</u>			Randal Riesett MD 1070	o Chalter Dr	Colum	DIG MI) 9104A				
		ate	31. Date filed (Month, Day, Year) 32. Figistrar's Signature JUN 2 0 2006	hout !							
	Regist	rar	JUN 2 0 2006 / Men B.	grave -							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Stoessell June 16, 2006 Margaret 7:45A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner 3865 Shamrock Court Port Republic Calvert If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 82 Months Days Hours 1 M 20 F Yrs 215-64-6693 France Director Dec 11 1923 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Maryland Calvert Port Republic Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code France 3865 Shamrock Court 20676 filed within 72 hours after death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Š 3 ☐ Widowed 4 1 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient Important: If Item 27 Is marked other tha any injury or other traumatic event. Ins. 2002. interior designer Design 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown uNknown Sefeve 2 19a. Informant's Name/Telationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl F. Hance- executor 4155 Hance Rd. Port Republic MD 20676 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Funeral Service Alexandria Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home aux N 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) kmentia. Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 13 Chamic 1 Yes 2 No 3 Probably 4 Unknown Complete 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this confidence on pipeline in hours. 1 Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one examiner Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JUME 16, 200 6 30. Name and address of person to completed cause of death (Item 23a) (Type, Print) TODOIG 110 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 1 9 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 13, Day 2006 Year Physician 10:13 P M Edward Smith /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda | Il Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Aug. 26, 1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2□F New York 71 Yrs. Director 111-28-6373 Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **⊕**how rthen "natural", or iteme 23a or 28e-f ehov the Medical Examiner must be notified at 1 Tyres 2 □ No Directo Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. A. 20853 14203 Castaway Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. other then "natural", or ite 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Research Pharmaceutical
Chemist 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government other item 27 is marked other other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 end 2 should be file Depertment of Health and Mental Hy Important: If flem 27 is marked oth eny injury or other treumatic event sons. 17. Father's Name (First, Middle, Last) Be Sara Smith Maurice Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Castaway Drive, Rockville, Maryland 20853 Eileen A. Smith - Wife 14203 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 6/16/2006 Falls Church, Virginia King David Mem. Gdns 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc.
1091 Rockville Pike, Rockville, Maryland 20852 21. Signature of Funeral Service License Donald 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each link. Approximate Interval Between Onset and Death Aspiration Pneumonia Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate has been signed by the attending physicien and rector, page 2 should be deteched for use as the buriel-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? þ Encephalopathy 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 24 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐XNo 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident in 24 hour.
The Funeral Director of the funeral place. 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 📉 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only опе) 29b. Signature 29c. License number 29d. Date signed (Month, Dev. Year) D62949 June 15, 2006 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Natasha Haag 8600 Old Georgetown Road Bethesda MD 20814 30. Name and address of person who com 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 16 2006 Registrar

		4	For State Registrar	State of	Marylan		artment rtificate			and M	ental Hy	giene Reg. No.	006	20856
10,7	Physicia	an	1. Decedent's Name (First, Middle,								June 1	Day	006 Year	3. Time of Death 11:50A M
	/Medic	al	Isabella Valanta 4a. Facility Name (If not institution,		ber)		4b. City, T	own, or l	ocation o	of Death	Julie 1		County of Dea	
	Examin	er	18637 Hedgegrove		,		01ne					Mot	ntgome	сy
	Funeral Director	64-	213-48-1004	6. Sex 7 1 □ M 2 💢 F	. Age (In yrs.	last birthday) O Yrs.	If Under 1 Months	Days Days	II Under: Hours	24 Hrs. Min.	8. Date of Bi (Month, D July 2	rth ay Year 19, 19	915 Was	rthplace (State or Foreign ountry) shington, D.C
	and II		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
	the Mary 28a-f sh	Director	Maryland Montgo	mery	01ne	у	10f. Žip (Code				10g. Citiz	zen ol What C	1 ☐ Yes 2 💆 No country?
	h with		18637 Hedgegrov	e Terrace			2083	2				USA		
336	d within 72 hours after death with the Maryland jane. Triten "natural", or Items 23s or 28s-f show tris Medical Examination incilited at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed Ford	es? ∑∑No		Was Decede II Yes, speci 1 Yes 2		panic Ori , Mexicar Specity:	gin? (Spe n, Puerto I	cify Yes or N Rican, etc.)		4. Race - Am Black, Whi Specify: Wh:	ite, etc.
Ċ	72 hou	Completed	15. Decedent' (Specify only highest			(Giva	dent's Usual kind of work	k done du	ırına mos.	t of workii	ng	16b. Kir	nd of Business	s/Industry
121	within ene. then "	mple	Elementary/Secondary (0-12)	College (1-4	4or 5+)	Homen	DO NOT use	e retired)				Own	Home	
d 2	o ≥ 5 = =		17. Father's Name (First, Middle, L	.ast)		пошеп	lakel		18. Mothe	r's Name	(First, Middle	1		
<u>lan</u>	a a a	To Be	(unk)		Rigg	gles			Mary	Cava	anaugh			
	s 1 and 2 should be fi f Health and Mental H item 27 is marked ot other traumatic ever		19a. Informant's Name/Relationsh Vicky Callow/gr		er								Town, State, D 2083	
Baltimore,	of Health of Health If item 27 I	- 1	20a. Method of Disposition 1 □ Burial 2 X Cremation	3 □Bemoval from S		Place of Disponentery, cre					ate		cation - City o	
Ë	Page of the Page o		4 □Donation 5 □ Other (Sp	pecify)	Che	esapeal								, Maryland
Ball	permit. Pag Department Important: any injury o		21. Signature of Funeral Service L	LHalit	MO12	251 Be	everly	Ц.	Неск	rotte	e, P.A	• CIA	P.O. Borksvil	ie, MD 21029
# *	Physician		23a. Part1. Enter the disease, or shock, or heart lailure. List of Immediate Cause (Final disease or condition	complications that ca only one cause on ea	ch line.							arrest,		Approximate Interval Between Onset and Death Years
760,	ate be executed We partie and whe burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate causs. Early Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (c	or as a consec or as a consec or as a consec	quence ol):								
O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		nth 2 ☐ Feta ant at time old	al death 3	⊒Ectopic pre ⊒ Other (spe					2	23d. Date of de Month	elivery Day Year
ds, P.O.	tw requires that to be seen signed by should be detail	by	Part II. Other significant condition		ath but not res	sulting in the u	underlying ca	ause give	n in Part I			tobacco u Yes 2		to the cause of death? Probably 4Unknown
Records,		Completed									per	s an opsy formed? 2 X No	24b. Were a prior to death?	autopsy findings available completion of cause of
/ita	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Otho			(Check only			
Division of Vital	ding After fune	lon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date o	npatient 2 f Injury n, Day Year)	ER/Outpatie 28b. Time o Injury		Bc. Injury Work			me 5 Res 28d. Describe		Other (Sp y occurred	ecify)
Division	If or Attending after death. I Director: After d in by the fune	Certification:	2 Accident INVESTIG 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place	ol Injury - At h ig, etc. (Speci	nome, farm, si	treet, factory	, office				(Street and own, State,		Rural Route Number,
_	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C		g Physician: To the Examiner: On the ba and mann	sis of examina									
	To the within 2 To the comple	Me	29b. Signature and title of certifier		0			. License						nth. Day, Year)
5				wer, m.				36552	2			June	16, 2	006
5	Tn,		30. Name and address of person P. Talwar, M.D.	50 W. Ed	monsto	n Driv		. Roc	kvi1	le,	MD 208	52		
	St Regist	ate rar	31. Date filed (Month, Day, Year)	9 2006 32. R	Strar's Sign	ature	beek	,						

		1	For Stete Registrer		State	of Marylan		artment rtificate			ind Me		giene ₂	005	20	85	7
			1. Decedent's Name (First,									2. Date of Dea Month	ith Day	Year	3. Time	of Death	
	Physicia /Medic	_	Betty	Mae	Turner							JUNE	16	2006	2:02	a ^N	Λ
,	Examin		4a. Facility Name (If not in:	stitution, gi	ve street and n	umber)				Location o				unty of Deatl			
			St. Mary's 5. Social Security Number	Hos		7 4 //2	fant birdhidaul	1		ardtv If Under:		8. Date of Birth		Mary		DE Coin	
В	Funeral		5. Social Security Number 5.78 – 3.4 – 7.3.4		Sex 1 ☐ M 2 5 7 F	7. Age (In yrs. 77	Yrs.	Months	Days	Hours	Min. Sen	" (Month, Da) tember	Year) 4	9. Birti 1928	wash	inot	or
	Director	L	Usual Residence of Deced								DCH	CCIIIDCI	,	1720	Wabii		
	yland now		10a. State 10b.	County		10c. Cit	y, Town or Lo	cation							10d. Inside	,	
	a-fet	cto	MD C	har1	es	P	ort T	obaco	20							s 2DN	<u> </u>
	or 28	Ë	10e. Street and Number		т			10f. Zip						n of What Co	untry?		
	within 72 hours after death with the Maryland ene. Than "naturel", or items 23a or 28a-f ehow ha Masical Examiner must be notified at	Funeral Director	6840 Gray	mar .					206		=:=2 /C==	aifu Van as Na	US	Race - Ame	rican Indian		
	er de Items	une	11. Marital Status	F3 Namind	Armed F	cedent Ever in U Forces?				n, Mexican	gin? (Spei n, Puerto F	cify Yes or No- Rican, etc.)	14.	Black, White	e, etc.		
36	rs aft	byF	1 Never Married 2 3 Widowed 4 D		If Yes, C	: 2 □ No Sive X Dates:		1 ☐ Yes 2	ZNo	Specify:			Sp	pecify: V	White		
21215-0036	2 hou		15. D	ecedent's E	Education	4)	16a. Dece	dent's Usua kind of wor	l Occupa	ation	t of workin	10	16b. Kind	of Business/	Industry		
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ุณ	filed wil Hygien other th	Completed	<u> </u>				на	ir Dı	cess		ode Name	/First Middle		utici	an		
nd	be filed within 72 hours after death with the Marylan had Hygiene. And Hygiene. And cher than "naturel", or items 23a or 28a-f show ad other than "naturel", or items 23a or 28a-f show event, in Macaisal Examiner must be notified at	Be	17. Father's Name (First,									(First, Middle, ice Sw		mame)			
<u> </u>	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the M	၉	Edgar Lew				19h Maili	na Address	(Street :			Route Numbe		own State 2	Zin Code)		
Maryland	d 2 st th and 7 is r treur		Sandra Wo			ohter	150. (114)	119 /1001000	(01/00/0				.,,		,		- 1
	Heat Heat tem 2	-	20a. Method of Disposition	n	-	20h (Place of Dispo	osition (Nam	ne of	a)	_ D	ate	20c. Loca	tion - City or	Town, State		
OL.	Pages ent of ht: if i		1 Burial Z Crer				insfi	eld-E	Echo	$1s \mid \epsilon$	5/17	/06 C	har1	otte	Hall	, MD	
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments important: If Item 27 is marked eny injury or other treumatic engles.	1	21. Signature of Funeral		-	M009	45 2	AREHA	Romes	ECHU	LS :	FUNERA	L HO	ME.P.	Α.		
ä	Depa Impo eny ir	11	Mave	1 C.	Chu	b		211_S	St.	Mary	7's .	Ave, I	a Pl	ata,N	ID 20	0646	
			23a. Part1. Enter the disc shock, or heart failu	ease, or co re. List onl	y one cause or	n each line.							rest,		Approxim Interval B Onset an	etween	
	Physician		Immediate Cause (Final disease or condition		а	CUNS C	Str	e L	29	1+	fa,	1402			129		
	/Medical Examiner		resulting in death)	- 1	Due t	o (or as a consec	quence of):	110							097	5	
	Examine	<u></u>	Sequentially list condition if any, leading to immedia	ns.	b. Due t	predo (or as a consec	quence of):	,,,,,									
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	ີ ⊀	SI	nock	duel	n se	751	5					Day	3	
Ć.	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	- 1	C. Due t	o (or as a consec that	quence of):	11	1						Mon	th s	
3760,	ate be executed thysicien and the burial-transit	cal		•	d	mai	55	7/10	000							<u>.</u>	
<u></u>	ntifica ng ph as th		IF FEMALE:	- I													
Вох	death certifics a ettending ph ad for use as t	an/I	23b. Was decedent pregi		1 ☐ Live	outcome of pregn a birth 2 Feta	aldeath 3	Ectopic pr		,			230	d. Date of dei Month	ivery Day	Year	
Ö.	ie dez tha e hed fo	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4∐Pre 9⊟Unl	gnant at time of o known	death 5	Other (sp	есту)								
P.O.	law requires that the deas been signed by tha eas should be detached f		Part II. Other significant	conditions	contributing to	death but not re	sulting in the u	underlying c	ause giv	en in Part I	l.	23e. Did t	obacco use	contribute to	the cause of	f death?	
ds,	uires sign ld be	d by	Paria	y sor	75 4	1 SE CL &	2					10	Yes 25	No 3□Pi	obably 4 l	Unknow	m
Records,	w requires that been signed to should be det	ompleted	P4114 (42n	116	Aven	112						24a. Was		24b. Were au	utopsy finding	gs availab	le
Re	0 = 0	E							-				rmed? 2j⊑ No	death?	completion of	cause of	
Vital	sicien: Th certificate irector. pag	ပ	25. Was case referred to	medical						26. Place	e of Death	(Check only o					
1	S S 5	To B	examiner? 1 ☐ Yes 21 No		Hospital:	npatient 2] ER/Outpatie	nt 3 DC	Oth Oth	er: 4 🗆 Nu	ursing Ho	ne 5 🗌 Resid	dence 6 (Other (Spe	cify)		
n of	D 0 0		27. Manner of Death	Pending	28a. Da (M	te of Injury onth, Day Year)	28b. Time of Injury		8c. Injur Wor	k?		28d. Describe	how injury o	occurred			
Sio	Tage of	cati	2 Accident	investigat	be -			М		Yes 2□		28f. Location (Ctront and	Number of P	ural Florita M	umbas	
Division	ii or Attending after death. i Director: Afte d in by the fune	Certification:	4 Homicide	determine	289. Pia	ice of Injury · At hiding, etc. (Spec		treet, tactory	у, опісе			City or To		VUITIDET OF A	urar Houle IV	umber,	
J	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th		29a. Certifier 115	Certifyina	Physician: To	the best of my kn	owledge, dea	th occurred	at the tir	ne, date ar	nd place,	and due to the	cause(s) ar	nd manner as	s stated.		-
	Hos 24 h Fur letely	Medical	(Check only 2 1	Medical Ex		basis of examin anner stated.	ation and/or i	nvestigation	, in my a	pinion, dea	ath occurr	ed at the time,	date and p	lace, and due	to the caus	e(s)	
	To the To the To the Complex c	Me	29b. Signature and title of	of certifier	~	9		290	c. Licens	e number			29d. Date :	signed (Mont	h, Day, Year	·)	
) M	1000				T)CC	100	719		Ju	ne 16	,2006		
(107		30. Name and address o	f person wt													
	1003		DHANAJAY V 31. Date filed (Month, Da	BHAV	SAR SH	AH ASSOC	HOLLY	WOOD	MD_	2063	36						
	St Regist	ate rar	.111	N 1 9	2006	e. S egistrar's Sign	H. A	park	<i>p</i>								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006

		•	For State Registrar	Olaic of IV	iai yiana		tificate of	Death		Reg. No.		20000
	Physicia	ın	1. Decedent's Name (First, Middle	e, Last)					2. Date of De Month	ath Pay	Year	3. Time of Death
	/Medic	al	IRIS M. WALTON 4a. Facility Name (If not institution	n, give street and number	.)		4b. City, Town,	or Location of Deat	SIONE	4c. Count	ty of Death	Q. 171.
	Examin	er A	er Die Her	Be Me	Syca	10	136/2	air		17	AR	1200
4	Funeral Director		5. Social Security Number 245–26–2149	6. Sex 7. A	ge (In yrs. las. 84	t birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da 5/31/1	th v. Year) 922	9. Birthp Court Nort	lace (State or Foreign http:// Carolina
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Loc	cation				1	0d. Inside City Limits
	Mary Isa	ţō	MD Har:	ford		Stree	t					1 ☐ Yes 2 ☐XNo
	or 28s	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of		itry?
•	ath wi	ral	3716 Grier Nur					1154			SA	and faction
220	ges 1 and 2 should be filed within 72 hours after death with the Maryland to fleatin and Mental Hygiene. If fleat 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Marchael Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married Marr 3 Widowed 4 Divorced	If Yes, Give	?]No		Yas Decedent of Yes, specify Cul	Hispanic Origin? (Span, Mexican, Puerlon) Specify:	pecify fes of No o Rican, etc.)	Spec	ace · Americ ack, White, ify: B1a	etc.
	72 ho	eted	15. Deceden (Specify only higher	t's Education st grade completed)		16a. Deced	ent's Usual Occu	pation during most of wo	rking	16b. Kind of	Business/Inc	dustry
7	within ane.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		nstress			Manuf	actur	ing
2	should be filed within nd Mental Hygiene. marked other than imatic event, the Mental count, the Mental	Be Co	17. Father's Name (First, Middle,	Last)				18. Mother's Nar	ne (First, Middle			
a	should be nd Mental marked o	To B	Richard Sim	npson					Ethel	Hopki	ns	
	2 sho and I le ma		19a. Informant's Name/Relations				•	tand Number or Ri Nursery R		•		Code) 154
ב ע	1 and 2 Health tem 27 l		Clarence E.	Walton/Hus	20b. Plac	e of Dispos	sition (Name of	T	Date Date	20c. Location		
allillo	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		1 Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	сет	tnut (atory or other pla Grove Ce	m. 6/26	/2006	Street		
g O	Depermit Deper Impor		21. Signature of Funeral Service	Il. You	elel	C Ha		uneral Ho			a, PA	17314
	Physician /Medical Examiner		23a Party Englished isease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Due to (or a	ed the death. line. A C/O / s a consequent	nce of):	Canca		c or respiratory a	rrest,		Approximate Interval Between Onset and Death (minimal)
,00/00	certificate be executed Iding physician and Ise as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a conseque							
O. BOX 6	death ce e ettendi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 200 No 9 □ Unknown		e of pregnanc 2 Fetal de at time of deal	eath 3	Ectopic pregnant	су			ate of delive	ery Day Year
rds, r	law requires thet the as been signed by th 2 should be detache	ρ	Part II. Other significant condition	ons contributing to death	but not resulti	ing in the ur	nderlying cause g	iven in Part I.		tobacco use co Yes 2 □ No		ne cause of death?
al Records	The ate ha	Completed							1 ☐ Yes	2X No	were auto prior to co death? 1 Yes	psy findings available mpletion of cause of 2 No
VITAI	Physician: rths certific ral director,	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 → No	Hospital:	tiont 2 TE	2/Outpation	t 3 DOA	than	ath Check only		ther (Specif	iv)
on or	P P	-	27. Manner of Death 1. Natural 5 Pendir	28a. Date of In		8b. Time of Injury	28c. Inj			how injury occi		,
DIVISION	To the Host ital or Attending within 24 hours after death. To the Fun ral Director: After completely illed in by the fune.	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 286. Place of I	njury - At hom etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (City or To		nber or Rura	ti Route Number,
	To the Hoseli within 24 hour To the Fun ri completely life	edical		ng Physician: To the best Examiner: On the basis and manner	of examinatio							
,	To th To th comp	Me	29b. Signature and title of certifie	ər			29c. Licer	nse number		29d. Date sign	ned (Month,	Day, Year)
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551	11		30. Name and address of person	the completed cause of the completed cause of the completed cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the cause of the complete cause of the complete cause of the complete cause of the complete cause of the cause of the complete cause of the complete cause of the cau	death (Item 2	23a) (Type,	AVII	us Bi	/ Air	Mary	land	21014
	Sta Regist			2006 3 Hegis	strar's Signatu	Fe Son	de			,		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 11:00 p^M Walker June 11 Anna /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner Anne Arundel 312 Severn Avenue Annapolis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 23, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 XX Yrs. 214-52-9688 56 1950 California Director Usuel Residence of Decedent 10d. tnside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural", or items 23s or 28s-f show the Medical Exercites must be notified at XXYes 2 No MD Anne Arundel Annapolis Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21403 312 Severn Avenue IISA death 1 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes Z No Specify: White Specify: 3 Widowed 4 Divorced ģ Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest ade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Teacher High School other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peges 1 end 2 should be nent of Health and Mental is marked Dorothy Newton George Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other train Kate Turner-Walker (Daughter) 1503 Crest Road, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ Removal from State ortant: 4 □ Donation 5 □ Other (Specify) Metro Crematory 6-14-2006 Baltimore, MD 21. Signature of Funeral Service Agensee 22. Name and Address of Facility
Hardesty Funeral Home, P.A Depai impor any ir once. 12 Ridgely Avenue, Annapolis, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician Juter1050 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, and because. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a considuence of Hospital or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of) Box 68760 Completed by Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) be detached f o the 9 Unknown 9 Orthown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate 1 Yes 2 D 10 Division of Vital : After this certifica e funeral director, f 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how intury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural s effer decrei rai Director: Afr 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Intury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours e To the Funeral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ess of person who completed cause of death (Item 23a) (Type, Print) NESIMD Signature 31. Date filed (Month, Day, Ye State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Sarah Alice Gluyas Whaley June 14. 2006 8:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Fairfield Nursing Center Crownsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months Days 1 ☐ M 2 🖾 F Yrs. March 10, 1920 Pennsylvania 158-09-4196 Director 86 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Florida Lake Leesburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò 23a 2 Aloe Way 34788 United States death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No 1942 − If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. or iteme 11. Marital Status filed within 72 hours after c Hygiene. other than "natural", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ School Principal Education other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any july or other traumatic event sone: Thomas Melrose Gluyas Blanche Leek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5009 Bridge Point Drive Chester, Maryland 21619 Henry H. Whaley / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State Baltimore Crematory 6/15/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Fyneral/Service Licensee Micha 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): acce clas /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ending physician and use as the burial-transit the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Ho
9 Unknown detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ģ signed to Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 W No 1 Yes 2 No al or Attending Physician: after death. I Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of Co 38958 30. Name and address of per n of death (Item 23a) (Type, Print) Highway Sw alin Burnie MD21061 51116 31. Date filed (Month, Day, Year) State 2006 Registrar

			For State Registrar	State of Marylar			t of Heal			jiene lag. No.	2006	208	861
			1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day	Year	3. Time o	f Death
	Physicia /Medic		Nicholas Zaf	iriou					June 28		006	4:00	ΑM
	Examin		4a. Facility Name (If not institution, give st 937 Winding Road	treet and number)			Town, or Local Igewate				County of Deat	_	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday,	If Unde Months		Inder 24 Hrs.	8. Date of Birtl (Month, Day	Year)	9. Birti Co	hplace (State untry)	or Foreign
	Director		212-92-9706	^{M 2□ F} 54	Yrs.	Montro	54,0		5/13/1	952		ecce	
	pu *	-	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or L	ocation						10d. Inside C	City Limits
	/anyli	5	Maryland Anne Aru	ndel	Edgev	water						1 🗆 Yes	2 🔀 No
	the N	Director	10e. Street and Number	inder	Lage.		Code			10g. Citiz	en of What Co	untry?	
	3a or	<u>a</u>	937 Winding Road				21037			US	SA		
	death ms 2	nera		Was Decedent Ever in L Armed Forces?	I.S. 13.	Was Dece	dent of Hispan	ic Origin? (Spe	cify Yes or No-	1	4. Race - Ame Black, White		
ထ္ထ	filed within 72 hours after death with the Maryland Hygions. the than "natural", or items 23s or 28s-f show ent, the Macical Examiner must be notified a	by Funeral	1 ☐ Never Married 2 X Married	1 ☐ Yes 2 [X]No If Yes, Give		1 ☐ Yes		ecify:	110411, 010.)			hite	
8	ural',	d b	3 Widowed 4 Divorced	Year or Dates:	10.0						· · · · · · · · · · · · · · · · · · ·	1-4	
Ω Γ	nett nett	lete	15. Decedent's Educ (Specify only highest grade	completed)	(Give		al Occupation ork done during se retired)	most of worki	ng	16b. Kin	nd of Business/	industry	
2	within	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) Years		ntrac	,			С	onstruc	tion	
D	Hygi other	BeC	17. Father's Name (First, Middle, Last)	7+	1		18.	Mother's Name	(First, Middle,	Maiden S	Sumame)		
Maryland 21215-0036	s i and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene them 23a or 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinator must be notified at	To B	Apostoles	Zafiriou		_		Efter	oi ————	Papa	azoglou	l	
lan	2 sho and f is me		19a. Informant's Name/Relationship (Typ	,				lumber or Rura				Zip Code)	
≥,′≤	and ealth m 27 her tr	1	Linda A. Zafiriou/		937 Place of Disp			Edge	water,		1037 cation - City or	Taura Stata	
Ö	ges 1 If Ite or of		20a. Method of Disposition 1 ☐ Burial 2 【▼Cremation 3 ☐ Re	emoval from State	cemetery, cre	matory or	other place)	6-29-					
Baltimore,	t. Pa rtant: rjury		4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License		alas C		_				water,		
Bal	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra pnce.		Mart I Ille					Facility George S Island					
			23a. Part1. Enter the disease, or complic	cations that caused the dea							acer, n	Approxima Interval Be	ite
	Physician		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	1	nel	anou	1a				Onset and	
7	/Medical		disease or condition resulting in death)	Due to (or as a consec								104	NOS.
	Examiner		Sequentially list conditions										
77	p #	ner	If any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quanta of):								
V	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. Due to (or as a conse	anopoo ot).								
8760,	cate be executed physician and the burial-transit	E E		200 10 (01 23 2 001301	quonico ory.								
687		edical	d										
Вох	eath certif ettending for use a	W/u	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn		□ r :				2	3d. Date of del	ivery	
	ne death the ette	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		□Ectopic p □ Other (s					Month	Day	Year
P.0	that the death ed by the ette detached for	hys	9 Unknown			-							
of Vital Records,	Se Co ed		Part II. Other significant conditions con	tributing to death but not re	sulting in the	underlying	cause given in	Part I.	23e. Dia to		se contribute to No 3 □ Pr		Unknown
Ö	> 0 0	Completed							24a. Was	_	9	itopsy findings	available
Re	elav has	m d							autop	sy med?	prior to death?	completion of	cause of
tal	ician: Th certificate ector, pag	ပိ	25. Was case referred to medical				26	Place of Death	1 ☐ Yes Check only o	2 No	1 ☐ Yes	2□ No	
>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 Ĉ\No	lospital: 1 Inpatient 2] ER/Outpatie	ent 3 D	Other	☐ Nursing Hor			G □Other (Spe	cify)	
0			27. Manner of Death 1 ☑ atural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time	of	28c. Injury at Work?	2	28d. Describe h	ow injury	occurred		
<u> </u>	Attending r death. ector: Atterby the fune	atlc	2 Accident investigation			М	1 🗆 Yes						
Division	or Att after de Direct	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec		treet, facto	ry, office	1	28f. Location (5 City or Tox			ıral Route Nui	mber,
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edical C		sician: To the best of my kn ner: On the basis of examin and manner stated.									(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier	-0		29	c. License nur	mber			e signed (Mont		
			> & Helou	usuo			019	1838		6/2	18/20	106	
	8		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type	Print)	00 B	estgate	Rd	An	28/20 10apoli	s lu	d.
, *		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	P	<i>y</i> .				*		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔈 🗍 🦺 🦰 For State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 30, 2006 Icarese AM **Physician** 0510 haron /Medical 4c. County of Death 4a. Facility Name (If pot institution, give street and number) 4b. City, Town, or Location of Death Examiner 3a Himore 8. Date of Birth (Month, Day, Year) N/A Bayview Hopkins PONVZ Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Number **Funeral** Days 1 □ M 2 🔀 F Marvland Director 213-44-9595 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State or 28a-f show or than "natural, or items 23a or 28a-f show the Medical Exacting at 1 Yes 2 No Funeral Director Baltimore N/A MD 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number 5914 Willet Avenue 21206 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. I∏Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Cashier permit. Pages 1 and 2 should be filed v Department of Heelth and Mental Hygie Important: If item 27 ie marked other II any injury or other traumatic event, ILA 2006. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frances Wilso Felix Guinto ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5914 Willet Avenue Baltimore, MD 21206 Albert Alcarese, Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07 03 2006 Baltimore Maryland Parkwood Cemetery 21. Signature of Funeral Service Licensee Alexandria J. Bates: 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 5305 Harford Rd. Baltimore, MD 21214 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Pancytopenia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or a a co sequence of) Examine the attending physicien and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 🗌 Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The pritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of gentilie hysician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian Silverman 4940 Eastern Internal 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUL 0 5 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** illiam MOSS 3:15 pm M 2006 Tule /Medical 4c. County of Death
Baltimore County 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltmore, MD
If Under 1 Year If Under 24 Hrs. 21237 Brook Avenue 6. Sex 8. Date of Birth February 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours ²⁴1944 1 □ M 2 □ F Months Baltimore Maryland 217 40 5467 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State rithen "naturel", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Baltimore Baltimore County Funeral Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 USA 5010 Shirley Brook Avenue death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes No Specify: Specify: White δ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bob Davidson Ford Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H tant: If Item 27 is marked of Marie Diepold William Amoss ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5010 Shirley Brook Avenue Baltimore, Maryland 21237 Thelma Amoss Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 5 Department of Important: If eny Injury or once. Metro Crematory Inc. July 5 2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lassahn Funeral Home Inc 21. Signature of Funeral Service Licenses 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Poset and Death 28/05 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 🗌 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification; 1 Natural 2 Accident 5 Pending 1 Tyes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

one)

2401

29b. Signature and title of certifier

Be IVE OR 31. Date filed (Month, Day, Year)

re

30. Name and address of person who completed cause of death (Items 23a) (Type, Print)

29c. License number

Baltimore

29d. Date signed (Month, Day, Year)

William

Trenue

		•	For State Registrar	State of Maryla	-	artment of H			giene Rag. No. 200	5 20864
			1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month		3. Time of Death
	Physici /Medic		Dorothy	Allan	_			07	0a 0b	10 21 PM
1	Examir		4a. Facility Name (If not institution, give			and the same of th	Location of Death		4c. County of Dea	
			COPPER R1 5. Social Security Number 6. Se	06E	. last birthday)	If Under 1 Year	UICCE If Under 24 Hrs.	8. Date of Birtl	Caeco	thplace (State or Foreign
	Funeral Director			M 20 F 97	Yrs.	Months Days	Hours Min.	(Month, Day	1909 PA	ountry)
	ס		Usual Residence of Decedent					rep 19	1909 1 A	
	arylan show	_	10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits
	Ba-f	ecto				1404 71 00 4			10-07	1 XYes 2 □ No
	within 72 hours after deeth with the Maryland ene. than "natural", or Iteme 23a or 28a-f ehow the Medical Exeminar must be notified at	by Funeral Director	14 Gregoria Court			10f. Zip Code 2121	.2		10g. Citizen of What C	ountry?
	teme.	nue.	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	rs afte	y F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 27 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify: wh	ite
21215-0036	2 hour	led t	15. Decedent's Edu	cation	16a Decer	tent's Usual Occurs	ation		16b. Kind of Business	
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21	giene giene er thu	Completed		+3	te	acher			music	
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lary	2 should and Men le marke aumatic		19a. Informant's Name/Relationship (7)						r, City or Town, State,	Zip Code)
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Baltimore,	Peges 1 ent of H int: If Ite		20a. Method of Disposition 1 Burial 2 Cremation 3 Cremation	Removal from State	cemetery, crer	sition (Name of natory or other plac rematory	7-8-06	Date	20c. Location - City or Interlache	
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Ba	Dependit. Dependit		Park Starter		P	.O. Box 1	.95 Sykesy	ille, M	eral Home ID 21784	& Chapel
П			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	lications that caused the dea ne cause on each line.	ath. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory are	rest,	Approximate Interval Between Onset and Death
,	Physician		Immediate Cause (Final disease or condition resulting in death)	END-STA	168	DEMEN	TIA			years
1	/Medical Examiner		resulting in dealtry	Due to (or as a conse	quence of):					
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9	ing pt		IF FEMALE:							
Вох	ath co	lan/	in the past 12 months?	23c. If yes, outcome of pregr	tal death 3	Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
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Vital	Physician: Th this certificete ral director, peg	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only or	ne)	
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<u>5</u>	al or la after	Certification;	4 Homicide	building, etc. (Spec	city)			City or Tow	n, State)	
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical (29a. Certifier Cartifying Phy (Check only one)	sician: To the best of my kr nar: On the basis of examin and manner stated.	nowledge, death nation and/or in	occurred at the time restigation, in my of	ne, date and place, pinion, death occurr	and due to the ded at the time, o	ause(s) and manner a date and place, and du	s stated. to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	, /		29c. License	e number	2	29d. Date signed (Mon	h, Day, Year)
			1 /Will	ya	MO	000	5813	7	7/3/6	
-	V		30 Name and address of person who co	ompleted cause of death (Ite	em 23a) (Type,	Print)	7 (160	tonined	e ND	21157
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	1		12.00		
	Regist	rar	JUL 0 5 2	006 Maria	13. 19	perte				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 18, 2006 **Physician** Peter G. BeVard 04:55 a^M /Medical 4a. Facility Name (If not institution, give street and number)
Suburban Hospital 8600 Old Georgetown 4c. County of Death 4b. City. Town, or Location of Death Examiner Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 13, 1953 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min XXM 2 F 53 Months Days Hours New York 072-44-9251 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. important: If Itam 27 is marked other than "netural", or Items 23s or 28s-1 show eny injury or other traumatic event, If a Medical Examinar must be notified. Montgomery 10c. City, Town or Location 10d. Inside City Limits 10a. State MD Potomac Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854 USA 10859 Deborah Dr. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. I∏Yes 2**X**No fYes, Give 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 20XNo Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Edward BeVard, Sr. Virginia Rose Fleming 195 Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code) 1934 Massachusetts Ave. McLean, VA. 22101 19a. Informant's Name/Relationship (Type, Print)
Jillian BeVard (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2/C/Cremation 3 ☐ Removal from State 06/28/2006 Falls Church, VA National Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility National Funeral Home 7482 Lee Hwy. Falls Church, VA. Zemi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Arkriosclerotic Cardiovascular disease Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner display to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2□ No 1 Inpatient 2 KER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) ۾ hours efter 4 ☐ Homicide Hospital or To the Hospital within 24 hours 6 To the Funaral Completely filled 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and titte of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19/2006 30. Name and agore is of person who completed cause of death (Item 23a) (Type, Print) Robert Nothstein 8600 Old Georgetown Rd. Bethesda, MD. 20814 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar 0 5 2006

Certificate of Death

Reg. No.

2. Date of Death

3. Time of Death

Physician
/Medical
Examiner

BENHOFF

PATRICIA

PATRICIA THERESA BENHOFF ž8 JUNE 2006 10:22PM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death TALBOT HOSPICE HOUSE EASTON TALBOT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) May 5, 1931 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2XF Months Hours Min. 75 Yrs 213-28-7933 Balto. MD Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show ad other than "natural", or Items 23s or 28s-f show 1 ☐ Yes 2 No MDQueen Anne's Grasonville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21638 1033 Long Point Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 0 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 Yes 2XNo Specify Specify: white Completed by 3XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within.
Department of Health and Mental Hygiene.
Important: If item 27 is menked other than "n
any injury or other transmission." Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) homemaker home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gordon Francis Phebus Gertrude Louise Forthuber P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Springhill Farm Ct. Hunt Valley, MD 21030 Melvin C. Benhoff, Jr. - son 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dulaney Valley Mem.Grds.7/3/06 Cockeys ville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, In 6500 York Road, Baltimore, MD 21212 Approximate Interval Between Onset and Death 23a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Von Swall Physician years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a nonsequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 FYes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan autopsy performed? /es 2 No 1 Yes or Attending Physician: Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE ျှ 1 ☐ Yes 2 ☑ No funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and Alle of certifier 29d. Date signed (Month, Day, Year) 29c. License number MZa 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29466 Pintail Drive Suite 5 David H. Smith, M.D. Easton, Maryland 21601 31. Date filed (Month, Day, Year) 32 agistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JUL 0 5 2006

			Please T	ype or Print in Bi State of Maryland					20067
		1	For State Amound #10.	Per FH G857				g. No.	2000/
			1. Decedent's Name (First, Middle,;Last)	Per FH G857			2. Date of Death)	3. Time of Death
	Physicia		Ch	arles	But	IER	5 Month	Sook Year	7 57 PM
	/Medic Examine		4a. Facility Name (If not institution, give s	treet and number)		y, Town, or Location of Deat		4c. County of Deatl	1/2
			SINAL HOSPITAL		1		CITY	7	1 A
TLER	Funeral Director		110-20-	7. Age (In yrs. la	st birthday) If Unit Yrs. Month	der 1 Year If Under 24 Hrs s Days Hours Min.		Year) Co	hplace (State or Foreign untry) aryland
BC.	Maryland	7	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	Africa As	0		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
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HAIL		erai	2004 R	12. Was Decedent Ever in U.S	13. Was De	cedent of Hispanic Origin? (5	Specify Yes or No-	14. Race - Ame	rican Indian,
9 5	72 hours after dea "naturel", or Items idical Examination	by Fund	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer 2019 No Specify:	to Rican, etc.)	Black, White	3 lock
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ZZ	ed wit	Completed	12th	NA	0	OOR Mathers No	me (First, Middle, M	,	
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Maryland	J Men narke	ဥ	19a. Informant's Name/Relationship (Ty		19h Mailing Addr	ess_(Street and Number or F	1	City or Town, State,	Zip Code)
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altir	Department Mportant: any Injury of		21. Signature of Funeral Service Licens			and Address of Facility	70 Fred	HILTON 1	Pass
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			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the death	. Do not enter the r	node of dying, such as cardia	ac or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SEPSIS					Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	ience of):				
	Examiner		Sequentially list conditions	PNEUMO					4
	ם ב	ner	Sequentially list conditions, if any, Lading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (units a conseign	ience of				
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Division of Vital Records, P.O. Box 68760	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. Il yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time ol de 9 □ Unknown	death 3 Ectop	c pregnancy (specify)		23d. Date of de Month	elivery Day Year
Ρ.	hat th d by detach	F.	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the underlyi	ng cause given in Part I.	23e. Did tot	bacco use contribute to	o the cause of death?
ds,	signe	l by	- DIABETES				1 □ Ye	es 2 No 3 P	robably 4 🛣 Unknown
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a	n: Th ficate or. pag		25. Was case referred to medical			26 Place of D	1 ☐ Yes : eath (Check only on		s 2 No
Ξ	sicia certi	o Be	evaminer?	Hospital: Inpatient 2	FR/Outpatient 3F	Other		ence 6 Other (Spe	ecify)
ð	Phy or this oral d	5. 70	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		ow injury occurred	,,
<u> </u>	Attending r death. octor: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(Monni, Day 16al)	М	1 ☐ Yes 2 ☐ No			
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	To the within To the comple	Me	29b. Signature and title of certifier			29c. License number	2	29d. Date signed (Mon	nth, Day, Year)
	C > F 0		E MARMY (inglomi, M	77	162-000) [SULY ZN'	700g

State Registrar

SINAI

HOSPITAL OF BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EUSENIO CINCOLANI MT S

31. Date filed (Month, Day, Year)

JUL 0 5 2006

32. Redistrar's Signature

			1 - For State Registrar	State of Maryla	nd / Depa <i>Cer</i>	rtment of F tificate of	lealth and Death		giene 0 0 6	20868
	Physicia		1. Decedent's Name (First, Middle, Last)	LANCHE OOL	00L00	BARRE	стт	2. Date of Dea Month		3. Time of Death 2:20 P M
	/Medic Examin		4a. Facility Name (If not institution, give s WESTMINSTI	etreet and number) ER NURSING	CENTE		or Location of Deat	h	4c. County of Dea	ılh
	Funeral Director		219-12-7061	7. Age (In yrs	i. last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		r, Year) C	rthplace (State or Foreign ountry)
	e Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County MD CARROL		WESTM	cation INSTER				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with th	al Director	10e. Street and Number 2201 OLD WASHIN	IGTON RD.		10f. Zip Code	21157		10g. Citizen of What C USA	ountry?
036	hours after death with the Maryland turel", or Items 23s or 28e-f show al Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:	11	Vas Decedent of F Yes, specify Cubi ☐ Yes 2X No	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Black, Whi	
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altimore,	Pages 1 nent of Hi ant: It Iter ary or oth		20a. Method of Disposition 1. □ Burial 2 □ Cremation 3 □ R □ □ Donation 5 □ Other (Specify)			sition (Name of patory or other place MEM • PA			20c. Location - City of	
Bait	Department Importent: eny injury once.		21. Signature eral Service License	,	2	54 E. M	AIN ST.	, WESTI	FUNERAL MINSTER, M	D 21157
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8760,	ficate be executed physician and a stransition to buriat-transitions.	dical Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
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Division of	ng Phy ter this neral d	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injus Wor	Nursing F		ence 6 □Other (<i>Sp</i> e ow injury occurred	ecify)
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	To the Hospitel of within 24 hours at To the Funeret D completely filled in	ledical	(Check only 2 Madical Examinations)	sician: To the best of my kr nar: On the basis of examin and manner stated.	nowledge, death nation and/or inv	estigation, in my o	opinion, death occu	urred at the time, d	late and place, and du	e to the cause(s)
	To Toon	¥	29b. Signature and title of certifier	CAS		29c. Licens			29d. Date signed (<i>Mon</i>	tn, Day, Year)
	M		30. Name and address of person who co OOURISHANAR 31. Date filed (Month, Day, Year)	mpleted cau death (Ite - NA L'ANN 32. Begistrar's Sign	A 700	Print)	OLE RI	O WEST	7/3/01 nnster	MD 21159
	Sta Registr		IIII 0 5 200		hature					

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ORIGINAL

		1- State Amend Item #5	ate of Maryland Per FH G857	/ Depa 7 7/19	irtmen 106 1116at	of He	ealth an Death	d Mental H	ygiene Reg. No	2006	20869
Physic	nian.	1. Decedent's Name (First, Middle, Last)						2. Date of D Month	eath Da	y Year	3. Time of Death
/Med		Linda Mae Bakewell						June	29	2006	
Exami	iner	4a. Facility Name (If not institution, give street	and number)		4b. City,	Town, or	Location of [Death	4c.	County of Death	
		Upper Chesapeake M	edical Ctr.	et hirthday)	Be1 If Under		If Under 24	Hrs. 8. Date of B	irth	Harfo	rd place (State or Foreign
Funera Director	_	5.299 S40 1084 6. Sex 10 M 3			Months	Days		Min. (Month, L	Day, Year)	Con	intry)
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nylan how		10a. State 10b. County	10c. City,	Town or Lo	cation						10d. Inside City Limits
Ba-f	cto	Md. Harford	Joppa	a							1 ☐ Yes 2☐No
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be filed within 72 hours after death with the Maryland hall Hygiene. Id other than "natural", or items 23s or 28s-f show avent, the Maxical Examinar must be notified at	Funeral	412 Ripplewood Rd.	as Decedent Ever in U.S.	12 1/	1		ognio Origin	2 (Coocity Van or h		14. Race - Amer	ican Indian
item item	Į,	Ai	as Decedent Ever in 0.3. med Forces? □Yes 2 2 No	13. 1	Yes, spec	ify Cubar	, Mexican, F	? (Specify Yes or Nuerto Rican, etc.)	10-	Black, White	
urs af	Þ.	lf lf	Yes, Give ear or Dates:	1	I ☐ Yes	No No	Specify:			Specify: Wh	ite
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ygier her th		12		Ноп	nemake		40. 84-45-4-	Name (First, Midd	(a. A.f.a.i.d.a.a.	Own H	ome
be find H dot	Be	17. Father's Name (First, Middle, Last) Joseph G. Stanka						Name (First, Midd. Brazda	ө, маюөп	Sumame)	
and yianin E.I.E. 2 should be filed within and Mental Hygiene. Is marked other than aumatic avent, the Manager aumatic avent, the Manager avent, the Manager avent, the Manager avent, the Manager avent, the Manager avent, the Manager avent, the Manager avent, the Manager avent, the Manager avent, the Manager avent, the Manager avent, the Manager avent a	2	19a. Informant's Name/Relationship (Type, P.	rint)	19b. Mailin	n Address	(Street a	nd Number o	or Rural Route Num	ber City o	or Town State 7	p Code)
17 or 18 or	1	Christopher W. Bake								21085	
s 1 e		20a. Method of Disposition	20b. Plac	ce of Dispos netery, crem	sition (Nan	ne of		Date		ocation - City or T	own, State
Page nent o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)		view M				ly 1, 200	6 Fa	allston,	Md.
permit. Pages 1 end 2 should by Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ances.		21. Signature of Funeral Service License	,	22	. Name an	d Address	s of Facility	Schimunek	Fune	eral Hom	e of Bel Ai
0 80E 5 5		Dien of Jain						Rd., Bel			
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	ns that caused the death. use on each line.	Do not ente	er the mod	e of dying	, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
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the de	Physician/M	1 Ves 2 VV	□Pregnant at time of dea □Unknown	ith 5∟	Other (sp	ecify)					,
that the ed by detac		Part II. Other significant conditions contribut	ing to death but not result	ing in the ur	nderlying c	ause give	n in Part I.	23e. Dio	I tobacco u	use contribute to	the cause of death?
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II. III.	BeC	25. Was case referred to medical					26. Place of	Death (Check onl)		1 1 1 1 1 1 1 1	ZUENO
hysic hysic his ce I direk	10	examiner? 1 Yes 2 No Hospit	1 Inpatient 2 E	R/Outpatien	t 3 🗆 DC	A Othe	r: 4 🗆 Nursi	ng Home 5□Re	sidence	6 □Other (Spec	fy)
oding P th. : After t		27. Manner of Death 28	a. Date of Injury 2 (Month, Day Year)	8b. Time of Injury		8c. Injury Work		28d. Describe	how inju	y occurred	
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or Ail after of Direction by	Certification;	4 Homicide determined 28	 e. Place of Injury - At hom building, etc. (Specify) 	ie, rarm, stre	eet, ractory	, office		City or T	own, State	nd Number or Hui n)	al Route Number,
spital ours neral		29a. Certifier 1 Certifying Physicien	: To the best of my knowl	ledge, death	occurred	at the time	e, date and p	place, and due to th	e cause(s	and manner as	stated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medicai	(Check only 2 Medical Examiner: 0	On the basis of examination and manner stated.	on and/or inv	estigation,	in my op	inion, death	occurred at the time	a, date and	d place, and due	to the cause(s)
To th withir To th	×	29b. Signature and title of certifier				. License				te signed (Month,	
		> Cusastul				000	634	20	700	e,29,	2006
7		30. Name and address of person who comple	ted cause of death (Item 2	23a) (Type, I	Print)	_					21014
		Dr. Zubair Siddiq, 1	Upper Chesap	eake	Hospi	tal,	500_I	Ipper Che	sapea	ke Dr. I	Bel Air, Md.
S Regis	tate trar	JUL 0 5 2006	32. Registrar's Signatu	conti	•						

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BAKewell 06/29/06

State of Maryland / Department of Health and Mental Hygiene 2 20870 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month July Mary Edna Brown 2006 4:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Manor Care Nursing Center-Rossville Rossville Baltimore 8. Date of Birth (Month, Day, Year) Aug. 22, 1914 Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

O 1 Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛛 F 91 213-36-7886 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-1 ehoveny injury or other traumatic event. If a Modical Exacultar must be notified at once. Maryland Baltimore 1 ☐ Yes 2 No Director Nottingham 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 4 Ratna Court 21236 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White δ 3 Nidowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George L. Dixon Georgia W. Tyson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Mohr (daughter) 4 Ratna Court, Nottingham, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Premation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Moreland Mem'l Park 7/6/2006 Baltimore, Maryland Signature of Furneral Service Lice 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd., Baltimore, MD 21236 Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, prock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imprediate Cause (Final disease or condition resulting in death) HIROXIA **Physician** /Medical Days PNEUMO NIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation f ⊡Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D55306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DENNIS HODIE 9106 PHLADERPHA 31. Date filed (Month, Day, Year) 327 Registrar's Signature State JUL 0 5 2006 Registrar

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			1 - For State Registrar	State of Maryland		artment of H			giene Reg. No.	06	20871
	Physici /Medio		1. Decedent's Name (First, Middle, Last Doris L. Bechtel					2. Date of De Month 07	02	^{Year} 2006	3. Time of Death 0315 a ^M
	Examir Funeral	ier	4a. Facility Name (If not institution, give 8820 Walther Blvd. 5. Social Security Number 6. Se	Unit 3305 x 7. Age (In yrs. i	ast birthday)	Baltimor If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	Balti	9. Birthpla	ce (State or Foreign
1	Director		219-10-2456 Usual Residence of Decedent 10a. State 10b. County	10c Cin	Yrs.		Hours Min.	01 10	1920		land d. Inside City Limits
	the Maryli 28a-f sho	Director	MD Baltimore		imore	10f. Zip Code			10g. Citizen o	of What Countr	1 ☐ Yes 2 🔀 No
	h with	ai Di	8820 Walther Blvd	Unit 3305		21234			U.S.A.		,.
9036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show event, it a Medical Exaction must be multiplial at	d by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1		Was Decedent of Hi. If Yes, specify Cubar 1 ☐ Yes 2 🏋 No	spanic Origin? (Spe n, Mexican, Puerto f Specify:	cify Yes or No Rican, etc.)	Spec	ace - America lack, White, et city: Whi	c.
Maryland 21215-0036	within 72 h iene. r than "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation e <i>completed)</i> College (1-4or 5+)	(Give life.	dent's Usual Occupa kind of work done d DO NOT use retired; Cretary	ation furing most of workir)	ng	16b. Kind of Govern	Business/Indu	istry
Pu .	be filed v tal Hygie d other i	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name				
ylaı	should be nd Mental marked	To	Edward J. Lubking				Louise St				
Mar	d 2 th a 7 ls		19a. Informant's Name/Relationship (T) Philip E. Bechtel.			ng Address (Street a Dover Rd.		ida, MD		m, State, Zip C	Code)
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F	20b. Pt		osition (Name of matory or other place		ate		n - City or Tow	n, State
Iţim	it. Pag rtment rtant: njury o		4 ☐ Donation 5 ☐ Other (Specify)	Hil		Service Co					and
Ba	Depa Depa Impo eny ic		21. Signature of Funeral Service Licens	°°Alexandria B ⊸		305 Harfo					
	Physician /Medical Examiner	her	23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a consequence).	Can Jence of):	er the mode of dying	g, such as cardíac oi	r respiratory ai	rrest,	1	Approximate nterval Between Onset and Death
,8760,	icate be executed physician and s the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent.	ience of):						
P.O. Box 6	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months 1 ☐ Yes 2 ☐ HO 9 ☐ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)				Date of delivery Month D	ay Year
	The law requires that the tee has been signed by the page 2 should be detache	۾	Part II. Other significant conditions con	ntributing to death but not resu	ilting in the u	nderlying cause give	n in Part I.		obacco use co ∕es 2 □ No		cause of death?
al Records,		Completed						24a. Was autop perfo 1 Yes	rmed?	Were autops prior to comp death? 1 \square Yes 2	y findings available pletion of cause of
Vital	Physician: r this certificanal director, i	To Be	25. Was case referred to redical examiner?	lospital:	ER/Outpatier	nt 3 DOA Othe	26. Place of Death □ 4 □ Nursing Horn	_		Abaa (Caaa ba)	
Division of	To the Hospital or Attending Phy within 24 hours alter death. To the Funeral Director: After this completely filled in by the funeral		27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 Italishing Hon		now injury occu		
Divis	ital or Att irs after de ral Direct	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify	·)			City or Tox			
	e Hosp 24 hot Fune letely fi	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, death ion and/or in	n occurred at the time vestigation, in my op	e, date and place, a inion, death occurre	nd due to the d d at the time,	cause(s) and n date and place	nanner as stat , and due to th	ed. ne cause(s)
)	To th within Comp	Me	29b. Signature and title of certifier	MD		29c. License	1685		29d. Date sign	dd (Month, Da	ky, Year)
	10.		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	than B	IVA. FR	to ku	VR.1	2	1234
	Sta Registr	_	31. Date filed (Month, Day, Year) JUL 0 5 200	32. Registrar's Signat	ure	and s		V		7 0	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 20872 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 2:52PM M June 30, Barbara Ann Blaylock 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2**∏**F Director Yrs. 244-44-2330 73 November 23, 1932 North Carolina Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location r then "natural", or Items 23a or 28a-f ehow the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 21 No Directo Montgomery Bethesda Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4977 Battery Lane #120 20814 by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Y Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Biological Researcher Health Research permit. Pages 1 end 2 should be file Department of Heelth and Mentel Hy Important: If Item 27 is marked oth any injury or other treumatic event 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Spencer Loraine Blaylock Stella Caviness 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert A. Blaylock/ Brother 103 Brookberry Court Jamestown, North Carolina 27282 20b. Place of Disposition (Name of complete, crematory of the place)
Oak Ridge United Methodist
Church Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ju₁y Oak Ridge North Carolina 2006 5 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 M00335 BETNESCA, MATYIAHU 20014-300

23a. Part1. Enter the disease, or complifations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M00335 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Clostridium Difficile Colitis Davs /Medical Due to (or as a consequence of): Examiner E.coli & Pseudomonas Pneumonia Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physicien and dbe detached for use as the burial-transit Sepsis with Septic Shock Days Due to (or as a consequence of): Physician/Medical Respiratory Failure Days 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by this certificate has been s al director, page 2 should 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 ☐ Yes 2 🔀 No 1 Minpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) Khama D0058965 July 1 2006 30. Name and address of person who completed cause of death (Item 2 a) (Type, Print) Saima U. Khawaia, M.D. 11119 Rockville Pike #100 Rockville, Maryland 20852 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 5 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Dolores J. Beauch 1:25 A M July 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice Casey House Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 17, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number 6 Sex **Funeral** 1 ☐ M 2 ☑ F 578-24-4638 1925 Pennsylvania 80 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f ehow d 2 should be filed within 72 hours after death with the Maryla. It and Mantal Hygiens. Fit and Mantal Hygiens. Fit is marked other than 'naturel', or iteme 23e or 28e-f ehov traumatic event, its Madical Examination that be invititied. Maryland Montgomery 01ney 1 ☐ Yes 20 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16920 Old Baltimore Road 20832 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 € Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifford Cunningham Eva 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iges 1 and 2 nt of Health a if item 27 is Lauren J. Beauch/Daughter 16920 Old Baltimore Road Olney, Maryland 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) July Date 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of h 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State permit. Page Depertment important: if any injury or Montgomery Crematorium 3, 2006 4 □Donation 5 □ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home 21. Signature of Funeral Service Licensee Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 John P. Chaples M00092 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ne death certificate be executed burial-transit Exami pug Due to (or as a consequence of) Box 68760, igned by the ettending physicien be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation 1 Yes 2 No 3 Probably 4 Unknown page 2 should been Hypothyroidism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 Yes 1 Yes 2 No 20 No To the Hospital or Attending Physicien: within 24 hours efter death.
To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2X No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D35635 July 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D. 6001 Muncaster Mill Road, Rockville, Maryland 32 Aegistrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 5 2006 Registrar

			1 - For State Registrar	State of Marylan	nd / Depa	artment o rtificate d	f Health a of Death		giene 2 0 0 6	20874
	Dhusia		1. Decedent's Name (First, Middle, Last)				2. Date of De.		3. Time of Death
	Physic /Medi		ALBERT RODNE	Y BOWEN, SE	₹.			JUNE	29, 2006	09:00am
1	Examir	ner	4a. Facility Name (If not institution, give				n, or Location of		4c. County of Death	
			COLLEGE MANO		1		THERVI:			IMORE
	Funeral Director		5. Social Security Number 6. Sec. 215-10-1347	7. Age (In yrs.	Yrs.	Months Da		Min. A PRIL	9. Birth	nplace (State or Foreign Intro) MARYLAND
			Usuaf Residence of Decedent							THE PRINCE
	anylan ahow	_	10a. State 10b. County BALTIM		y, Town or Lo					10d. Inside City Limits
	Ba-f a	cto			IAM					1 ☐ Yes 2 ☐ XNo
	with th	Dire	10e. Street and Number 1515 ARMACOST	ROAD		10f. Zip Cod	^{le} 21120		10g. Citizen of What Cou	intry?
	eath	erai	11. Marital Status	12. Was Decedent Ever in U.	S 113			in? (Sassify Var or No	USA 14. Race · Amer	ioan Indian
336	72 hours after death with the Maryland natural', or itema 23a or 28a-f ahow Jasal Examiner must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1XIYes 2 □ No WW IfYes, Give Year or Dates:		If Yes, specify C		in? (Specify Yes or No Puerto Rican, etc.)		
ğ	2 ho	Completed	15. Decedent's Edu		16a. Dece	dent's Usuaf Oc	cupation		16b. Kind of Business/li	ndustry
21	thin 7	npie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			ne during most tired)	or working		
7	filed within Hygiene. Ither than "	Cor		5+	АТТО	RNEY			LEGAL	
Maryland 21215-0036	b la b	To Be	17. Father's Name (First, Middle, Last) ALBERT BOWEN					's Name (First, Middle, ENE STYLE	Maiden Sumame)	
	12 should head 7 is m		19a. Informant's Name/Relationship (Ty ALBERT BOWEN,	JR • son	19b. Mailir 151	ng Address (Str 5 ARMA	eet and Number COST R	or Rural Route Number	r, City or Town, State, Zi	p Code) . 120
Baltimore,	Pages 1 and nent of Healt int: If item 2: iry or other i		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	1 0	ameteru cret	sition (Name of natory or other) NATI	niaca)	Date UG 14, 20	20c. Location - City or T	
Baltii	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License		22	. Name and Ad	dress of Facility	HENRY W.	JENKINS	& SONS CO
2	icate be executed XX Medical physicien and physicien and strength in the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of):	cliced		ardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
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Φ.	uires thet signed by ld be deta	by	Part II. Other significant conditions cor	ntributing to death but not resu	alting in the ur	nderlying cause	given in Part I.		bacco use contribute to t	
Division of Vital Records,	The law requires thet sete has been signed b page 2 should be deta	Completed						24a. Was a autop	by prior to co	opsy findings available impletion of cause of
		Be C	25. Was case referred to medical			07-10-1	26 Blace	1 ☐ Yes Death (Check only or	2 No 1 Yes	2 No
<u> </u>	yaici Is cer direc	To B	examiner?	lospital:	EP/Outpatien	3 DOA	Other		ence 6 ⊟Other (Specif	(v)
io noi	nding Ph ath. r: After th e funeral		27. Mann of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Ir		28d. Describe h	ow injury occurred	<i>y</i> ,
Divis	al or Atta s after des il Diracto id in by th	Certification:	3 Suicide 6 Could ot be 4 Homicide detarnined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office	>a	28f. Location (S City or Town	treet and Number or Rura n, State)	al Route Number,
	To the Hospital or Attanding Physician: within 24 hours after death and 1.2 to the Funeral Director; After this certific completely filled in by the funeral director,	edicai	29a. Certifier Certifying Phys	sicien: To the best of my knowner. On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the estigation, in m	time, date and y opinion, death	place, and due to the coocurred at the time, d	ause(s) and manner as s ate and place, and due to	tated. o the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier			29c. Lice	ense number	2	9d. Date signed (Month,	Day, Year)
			Cascul	uca/M)		DZ	24/21		6/29/01.	
	140	H	30. Name and address of person who co	mpleted cause of death (Item	23а) (Туре, І				1 1/2	
	١σ			FNATTAR	211	WEST	120	TOWS	ON, MDZ	1204
	Sta Registr	_	31. Date filed (Month, Day, Year) JUL 0 5 2006	mpleted cause of death (Item	ture for the		W=355		/	•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#18,psrthe 857/7/1/100 TDepartment of Health and Mental Hygiene () () 6 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2006 **Physician** Crawford Sr. June a^{M} George 10:25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges 15704 Dorset Road Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Hours Min (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 3 M 2 □ F Oct. 26, 1928 Michigan 77 386-26-9755 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28s-f show other traumatic event, It a Medical Examinar must be nutilised at 1√ Yes 2 No Director Maryland Prince Georges Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20707 15704 Dorset Road United States America "netural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1, Yes 2 No If Yes, Give Year or Dates: 51 -53 filed within 72 hours after 1 ☐ Never Married 2√ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Business Manager Haines & Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Cooper Peter G. Crawford Laurel Maryland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DeLois Crawford/Wife 15704 Dorset Road Laurel Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Depertment of H
Important: if ite
any injury or oti 1 ★ Burial 2 Cremation 3 Removal from State 5 Other (Specify) Maryland National Mem. Pk. 6/29/2006 4 Donation Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel Maryland with me 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple Sclerosis Years Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai use as the IF FEMALE 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy performed? 1 ☐ Yes 2**X** No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: ours efter death.

nerel Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 fnpatient Other: 4 Nursing Home ٩ 1 ☐ Yes 2 ☐XNo 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28c. fnjury at Work? 27 Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide within 24 hours e To the Funerel I 29a. Certifier KKCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D43575 6/29/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angela Dunkin, M.D. 7350 Van Dusan Road Laurel Maryland 20707 32. Pegistrar's Signatur 31. Date fifed (Month, Day, Year) State 0 5 2006 Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Melvin Craddock June 0130 2006 /Medical 4a Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University Number 5. Social Security Number HOSPITAL Altimore E Inder 24 Hrs. 8. D 6. Sex / 1 ☑ M 2 ☐ F If Under 1 Year (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 220-54-3193 56 Yrs. Director 11-30-49 Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits nit. Peges 1 end 2 should be filed within 72 hours attar deeth with the Maryle antment of Health and Mentel Hygiene. ortant; if item 27 is marked other than "naturel", or items 23e or 28e-1 ehou injury or other traumetic event, the Medical Examinat must be notified at 1 X Yes 2 □ No Directo Md. NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1008 Bonaparte Avenue 21218 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 MgYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Š Specify: 3 ☐ Widowed 4 ☐ Divorced Black aitimore, Maryiand 21215-00 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Patient Escort 12th grade Johns Hopkins Hospital RADDOCK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Craddock, Sr. Geraldine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parmit. Peges 1 end 2 a Dapartment of Health ar important; if item 27 is any injury or other trau John A. Craddock, Jr. Brother 3624 Kenyon Avenue, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State I ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) King Mem. Pk. 6-30-06 Randallstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examine 2 W/C or Attending Physicien: The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical that initieted events resulting in death) Last Due to (or es a consequence of): attending i signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? s cartificate has b director, pege 2 s TLIYES 2LINO 1 Tes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 TYes 2 No After this 28c. Injury at Work? 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation after death.

I Director; After in by the fu 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funerel D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CPnehta MD D34974 June 29th 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
CHARUMEHTA, MD. 601 South Charles Street, Baltimore, MD 21230 31. Date filed (Month, Day, Year) 32. Signature -State Registrar 2006

DHMH 16 Rev 6/95

			1 - For State Registrar	State of M	larylan		artmen rtificat			and M	lental Hy	giene		06	2 (087
	Dhyaia		1. Decedent's Name (First, Middle	*							2. Date of De	ath			3. Time	of Death
	Physic /Medi		MARY	64	ARK	_					JUN E	Da:		oar	11:	35AM
	Examir	ner	4a. Facility Name (If not institution,	give street and number)		4b. City,	Town, or	Location of	of Death		4c.	County of	Death		
				S SAY VSIEW					TIM							
	Funeral Director		216-34-4623 Usual Residence of Decedent	1 □ M 2 🔀 F	69	last birthday) Yrs.	If Under Months	Days	If Under : Hours	Min.	8. Date of Bir (Month, Da 2-11	th ay, Year) -193	7	9. Birthpl Count	N.C	or Foreign
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10	d. Inside (City Limits
	Sa-f s	ctor	Md	N/A		Balto									1 X Ye	s 2 No
	th with th	ai Director	10e. Street and Number 5505 Hopkins Ba	yview Circl	.e		10f. Zip	Code 212	24			-	zen of Wh	at Count	ry?	
9600	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examine court be notified at ances.	by Funeral	11. Marital Status 1 ሺ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces of 1 Yes 2 X If Yes, Give Year or Dates:	Ever in U. P No	1	Was Deced if Yes, spec 1 Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.))-	14. Race - Black, Specify:	America White, e Blac	tc.	
Maryland 21215-0036	d within 72 h jene. r than "natu	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 8th grade	Education grade completed) College (1-4or	5+) N/A		dent's Usua kind of wor DO NOT us	rk done d se retired,	luring most)	of works	ng	16b. Ki	nd of Busi	ness/Indi	ustry ur	nk
yland ;	ould be filed Mental Hyg arked oths	To Be C	17. Father's Name (First, Middle, L Robert B. Clar	c				M	18. Mother	Ander						
e, Mar	1 end 2 sho lealth and sm 27 is m ther traum		19a. Informant's Name/Relationshi Stephany Brawne: 20a. Method of Disposition		205 8		Brig	htor	nd Number	eet	Balto,	Md	21216	,		
Baltimore,	t. Pages rtment of h rtant: If Itu		1 Burial 2 Cremation : 4 Donation 5 Other (Spe	ocify)	٥	emetery, cren tro Cre	natory`or or omator	ther place rv	6.	-30-	2006_ /.	Cato	cation - Ci			
Ba	Dermi Depe Impo any Ir		21. Signature of Funeral Service Li	A. Dhu	mpo	w		4300) Wab	ash	Avenue	Ва	lto,	Md 2	21215	
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	ficate be executed XX physicien and XX III is the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as												
.O. Box 68	The law requires that the death certifica sie has been signed by the ettending ph bage 2 should be detached for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant al 9 ☐ Unknown	2 Fetal	death 3 🗌	Ectopic pre Other (spe					2	3d. Date o			Year
rds, P.	w requires that been signed t should be deta		Part II. Other significant condition	s contributing to death b	ut not resu	Ilting in the un	derlying ca	iuse givei	n in Part I.		23e. Did to	es 2			cause of c	
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:	vithin 24 hours el To the Funers! D completely filled i	ledicai	one)	Physician: To the best aminer: On the basis of and manner sta	examinati	vledge, death ion and/or inv	occurred a estigation,	t the time in my opi	, date and nion, death	place, ar	nd due to the c	ause(s) a late and	and manne place, and	r as state due to th	ed. e cause(s	5)
i	To	Σ	29b. Signature and title of certifier				29c.	License	number		2	9d. Date	signed (N	lonth, Da	y. Year)	
	18	-	30. Name and address of person wh	on , MB > SCA C				55 - c	000			JUN	€ 28	٠, 2	006	
	"		DR CHRISTOPHER T			23a) (Type, P	rint)		A D	LTIM	44 44	a	2122			
	Sta: Registra	te	31. Date filed (Month, Day, Year)	2000 32. Redistra			bade)	D/II	17 %	, , , , , , , , , , , , , , , , , , ,		-152	7		

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 1144 AM Konuld June ZODL Crockett /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Columbia Honard County General If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Sex 12 M 2□ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Vrs 181-28-2397 69 29. 1936 Pennsylvania Director Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Itams 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Howard Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7930 Anfred Drive 20723 USA by Funeral be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? ★XYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married XX Married Maryland 21215-0036 1 ☐ Yes XXNo Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12th Analyst US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F . Pages 1 end 2 should be thent of Heelth and Menta tant: If Item 27 is marked ilury or other treumatic so Warner Crockett Ester Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary F. Crockett/ Wife 7930 Anfred Drive, Laurel, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If sny injury or West Arundel Crem. 7/1/2006 Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee 313 Talbott Avenue, Laurel, MD Jame Nandsan M00160 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute myocardial infaction **Physician** /Medical years Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine The law requires that the death certificate be executed attending physician and for use es the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð Rheumstond arthertis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed 1 Yes 2 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospitel or Attending 5 Pending investigation Natural 1 Tes 2 No within 24 hours after death. To the Funers! Director: A 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Varietying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) June 28 200% Mune no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box 68760.

moore 31. Date filed (Month, Day, Year) State

2006 JUL 05

32. Pegistrar's Signature

4801

Dorsey Hall Drive

ELLICOTT CITY MD

DHMH 17 Rev 1/2001

Registrar

		•	State of Maryland / Department	artment of Health and Mertificate of Death	lental Hygien Reg. N	2000 20017
	Physicia		1. Decedent's Name (First, Middle, Last) HELEN CARTER		2. Date of Death Month D	ay 2006 3. Time of Death P 23 1.52. M
a	/Medic Examin		4a. Facility Name (If not institution, give street and number) NDRTHWEST MOSPITAL CTR	4b. City, Town, or Location of Death RANDALLS TO U	4	c. County of Death BAUIMDIE
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) $214-16-5085$ 1 M $2 \square$ F 84 Yrs.		8. Date of Birth (Month, Day, Yea	
	g		Usuef Residence of Decedent 10a. State 10b. County 10c. City, Town or Le	ocation		10d. fnside City Limits
	he Mary Be-f sh	Director	MD Carroll	Eldersburg	100.0	1 Tes 2 No
	h with ti	al Dir	10e. Street and Number 2032C Rudy Serra Drive	21784	109.0	USA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydjene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show strip filety or other traumatic avent, The Medical Examinar must be motified at once.	by Funeral	1 Never Married 2 Married 1 Yes 2 WNo	Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ Mo Specify:	ecify Yes or No- Rican, etc.)	14. Race · American Indian, Bfack, White, etc. Specify: White
Maryland 21215-0036	thin 72 hou e. sn "nature Medical E	Completed	(Specify only highest grade completed) (Give life. Elementary/Secondary (0.12) College (1.4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/Industry
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ylan	should be ind Mental marked o umatic svs	To Be	? Trogler		known	
	and 2 shi salth and n 27 is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mail Mrs. Charlotte Bareford (Daughter) 20a. Method of Disposition 20b. Place of Disp	ling Address (Street and Number or Run 693 French Avenue		
ore,	Pages 1 arent of Hearnint: If item		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ematory or other place)		
Baltimore,	permit. Pa Departmer Important eny injury			ige Mem. Park 7/7/ AATGAT AFUNEKAL HOM		kridge MD . PA (Box 195)
6	89 E 2 9		23a, Part 1, Enter the disease, or complications that caused the death. Do not en	Sykesville, MD 217 nter the mode of dying, such as cardiac	84 (410) - 7 or respiratory arrest,	95-1400 Approximate
	Physician		shock, or heart failure. List only one cause on each line.	TESTINAL HE		Opent and Dooth
ı	/Medical Examiner		Due to (or as a consequence of):			
	red or sit	Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury			
8760,	icate be executed physician and sthe burial-transit	dical Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
P.O. Box 68	ne death certif the attending thed for use as	Completed by Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	w requires that the been signed by should be detact	ed by Ph	Part If. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part f.		o use contribute to the cause of death?
Division of Vital Records,		Complet			24a. Was an autopsy performed? 1 Yes 2 □ N	
r Vita	Physician: The rule certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: Impatient 2 ☐ ER/Outpatie	Other	th (Check only one) ome 5 Residence	6 ☐Other (Specify)
ion o	Σ		27. Manner of Death Natural 5 Pending 28a. Date of Injury 28b. Time (Month, Day Year) 5 Pending investigation 1 1 1 1 1 1 1 1 1		28d. Describe how in	jury occurred
Divis	ef or Attendir s after death. Il Director: Af id in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Initury · At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital of within 24 hours at To the Funeral Discompletely filled in	Medical C	29a. Certifier (Check only one) 12 Gerifying Physician: To the best of my knowledge deal (Check only one) 13 Gerifying Physician: To the best of my knowledge deal (Check only one)			
	To the vit in 2 To the comple	Me	29b. Signature and title of certifler	29c. License number		Date signed (Month, Day, Year)
	4		30. Name and address of person who completed cause of death (Item 23a) (Type	D 53910	0	7/02/2006 VDAUS 90WN, MD
	6		A. MA HESH NAPI, MD NURST	HWEST HUSPI	TAL , RM	VDALLS TOWN, MD
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	breste		

DHMH 17 Rev 1/2001

ORIGINAL

	1	For State Registrar	State of Maryla		artment of F rtificate of		d Ment		ene g. No.	006	2088
		1. Decedent's Name (First, Middle, Last)						ate of Death	Day	Year	3. Time of Death
Physicia	_	JEROME	C	MEN			(July 1	2	2006	14179
/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of D	Death		4c. C	ounty of Death	
		NORTHWEST H	OIPITAL		RM	PALLST	OWN		6	ALTIMO	RE
Funeral Director		5. Social Security Number 6. Sex 215-22-4699	M 2□F 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. D	ate of Birth	928	9. Birthi	place (State or Fore ntry) MD
all will the Marylation 123s or 28s-f chow		Usual Residence of Decedent 10a. State 10b. County MD BALTI		BALT	IMORE						10d. Inside City Limi 1 □ Yes 2 💢 t
3a or 28	al Dire	10e. Street and Number 3916 SOUTHERN CR	OSS DRIVE		10f. Zip Code	2120	7	10	g. Citize	en of What Cou	USA
within /z nouts after death with the maryland ene. Then "natural", or itema 23a or 28a-f ehow he Modical Examiner r wat be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🎵 No	dispanic Origin an, Mexican, F Specify:	n? (Specify ' Puerto Ricar	Yes or No- n, etc.)		Race - Ameri Black, White,	
be lied within 72 hours after de lial Hygiene "naturel", or Itams event, the Medical Examiner r	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire SMAN	during most o	f working	1		of Business/Ir	
matic event, I	To Be C	17. Father's Name (First, Middle, Last) SAMUEL		СОНЕ	EN		REBA	st, Middle, M	aiden S	umame)	FARBER
permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked eny injury or other treumatic e 2002.		19a. Informant's Name/Relationship (Ty, ROSLYN COHEN - W. 20a. Method of Disposition 1 ○ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Faneral Service License	IFE 20b.	3916 Place of Disponentery, cre LTIMORI	SOUTHERN Southern Southern Southern Solition (Name of matory or other pla E HEBREW 2. Name and Addre	CROSS CEM. 0 ess of Facility	DRIVE Date 7/ 04, SOL	E - BA /2006 LEVIN	LTIM OC. LOCE RE SON	MORE, MI ation - City or T EISTERS	O 21207 own, State TOWN, MD
Physician /Medical - Xaminer - Aminal-Itansit	dicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Either Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):			ardiac or res	piratory arre	st,		Approximate Interval Between Onset and Death
itte fam requires that the death beatings is to has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnanc □ Other (specify) _	у			23	3d. Date of deliv Month	rery Day Year
n signed by	Ď	Part II. Other significant conditions con	itributing to death but not r	e <i>sul</i> iting in the a	inderlying cause gr	ven in Part I.			acco us		the cause of death? bably 4 Unkno
	Completed								ed?	24b. Were aut prior to co death? 1 ☐ Yes	opsy findings availa ompletion of cause 2 No
is certificate director, pag	Be	25. Was case referred to medical examiner?	lospital:		O:	har		eck only one			
After this funeral di	tlon: To	27. Manner of Death 1 ZNatural 5 Pending	1 ⊠Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju	4 🔲 Nurs	28d.	5 Reside Describe ho		Other (Spec	ify)
frer deal	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, si cify)			28f.	Location (Str City or Town		Number or Rui	ral Route Number,
To the Hospital within 24 hours a To the Funeral C completely filled in	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, dea nation and/or i	th occurred at the to nvestigation, in my	ime, date and opinion, death	place, and occurred a	t the lime, da	ite and p	olace, and due	lo the cause(s)
Yithii To II Comp	Σ	29b. Signature and title of certifier			29c. Licen	se number		29	d. Date	signed (Month	. Day, Year)
b		30. Name and address of person who co	ompleted cause of death (II			00059	736		J	neg.	2, 2006
/	ate rar	OESO RAH WAT 31. Date filed (Month, Day, Year)		. 0) (Pauli con	HOSPIT	AL	5401	0	ر م	OURT ROAD

			For State Registrar	State of Marylan	id / Depa <i>Cer</i>	rtment o tificate	of Healt of Dea	th and M ath		giene 200	6 20881
			Decedent's Name (First, Middle, Last)						2. Date of Dea	ath	3. Time of Death
	Physicia /Medic		JOHN BARRY	DIGNEY					June June	29, 2006	8:59 P. ^M
,	Examin		4a. Facility Name (If not institution, give s			4b. City, Tov	vn, or Locat	tion of Death		4c. County of Dea	th
			Union Memorial Ho				imore			N/A	
	Funeral Director		5. Social Security Number 6. Sex 104–28–3290	M 2□F 7. Age (In yrs. 75	last birthday) Yrs.	If Under 1 Y Months D	ays Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day Aug. 19	v, Year) C	thplace (State or Foreign ountry) V York
	P .		Usual Residence of Decedent	140-00	Ŧ						10d. Inside City Limits
	arytar show	_	10a. State 10b. County		ty, Town or Lo						1 X Yes 2 No
	Ba-f	ecto	Maryland N/A		<u>Baltimo</u>					10g. Citizen of What C	
	with t	吉	10e. Street and Number 203 Kemble Road			10f. Zip Co		11.0		U.S.A	
	eath	era		2. Was Decedent Ever in U	.S. 13. V	Vas Deceden	212 of Hispanio		ecity Yes or No-		
36	should be filed within 72 hours after death with the Maryland and Manalla Hygiene. Hygiene. The Hygiene 23a or 28a-f show marked other than "natural", or iteme 23a or 28a-f show martic event, the Modical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 📉 Married	Armed Forces? 1 XYes 2 □ No		fYes, specify I□Yes 2 X		xican, Puèrto ecity:	acify Yes or No- Rican, etc.)		nite
ë	hour:	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: Kore	1	ient's Usuaf C	ecupation			16b. Kind of Business	
21215-0036	n 72 "nai	Completed	(Specify only highest grade	completed)	(Give	kind of work of	lone during etired)	most of work	ing	rob. King of Business	villadatiy
7	iene.	mo	Elementary/Secondary (0-12)	Colfege (1-4or 5+) 5+ years		Atto	rney			Law	
ਰੂ	other other	BeC	17. Father's Name (First, Middle, Last)				18. N	nother's Name	(First, Middle,	Maiden Sumame)	
<u>a</u>	Alenta Alenta rrked ric ev	To B	John Barry Digne	У			Er	nily	Gav	in	
	is 1 and 2 should lot Health and Ment Item 27 le marke other traumatic (19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	g Address (S	reet and No	umber or Rura	al Route Numbe	er, City or Town, State,	Zip Code)
	1 and 2 Health em 27		Rosemary D. Digney	(wife)		emble 1		Baltin	nore, M	aryland 212	18
ore	of H of H if Iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		Place of Dispo cemetery, cren	sition (Name natory or othe	of r place)		Date	20c. Location - City or	Town, State
Ē	Pages Iment of I tant: If Ito		4 □ Donation 15 □ Other (Specify)	Gre	een Mou	ınt Cre	mator	y 7-1	-06	Baltimore,	Maryland
Baltimore,	permit. Pages Depertment of Important: If It any injury or once.	l la	21. Signature of Funeral Service License	00	M:	Name and A itchel 5500 Yo	ddress of F L-Wiec ork Ro	defeld bad Ba	Funeral	L Home, Inc e, Maryland	21212
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the deat	th. Do not ent	er the mode o	f dying, suc	h as cardiac o	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Finaf disease or condition	17	vasc	ubo	Co	1/20	05.0		One hour
	/Medical		resulting in death)	Due to (or as a consec		0 1011		1101	30		0.0770077
	Examiner		Sequentially list conditions b	_ ===							
/	φ ÷	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						
6	ecute and -trans	Examine	that initiated events resulting in death) Last	. Due to (or as a consec	moses at).						
60	licate be executed physicien and s the burial-transit	E		200 10 (0) 83 8 00/300	(46/106/01).						
68760,	physicate physicate	dlcal	d								
×	certif ding se as	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna						23d. Date of de	livery
Вох	death death	Physician/M	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of c]Ectopic pregi] Other (s <i>peci</i>			·	Month	Day Year
P.O.	t the c by the achek	hysl	9 Unknown	9□Unknown					-		
ις. σ	s tha	by P	Part II. Other significant conditions con	•	sulting in the u	nderlying caus	e given in F	Part I.		obacco use contribute t	
ğ	equire en sig ould b		Hypothyro	idism					101	res 2□No 3□P	robably 4 Unknown
၁၃	law re as be 2 sho	plet	Merbid .	obesity					24a. Was	an 24b. Were a	utopsy findings available completion of cause of
Ě	The ete ha	Completed							perfo 1 ☐ Yes	rmed2/ death?	s 2016
ita	sian: artific ctor,	Be (25. Was case referred to medical examiner?		1		7	Place of Deatl	h (Check only o	ne)	
<u>></u>	hysio this o	မ	1 □ Yes 2 No	lospital: 1 ☐ Inpatient 25	ER/Outpatien					dence 6 Other (Spe	ecify)
E C	ling F After unera	on:	27. Manuar of Death 1 ○ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of fniury		Work?		28d. Describe i	now injury occurred	
isi	death death stor:	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	omo form etc	M cot feeten, o	1 Tes		28f Location /9	Street and Number or F	Pural Poute Number
Division of Vital Records,	after after I Direct	Certification:	4 ☐ Homicide determined	building, etc. (Speci	fy)	eer, ractory, o	nice		City or Tox		urar Adule Ivaniber,
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use as	edical C		sician: To the best of my known or the basis of examinating and manner stated.							
	ithin (ithin or the or	Med	29b. Signature and Little of certifier	and marrier stated.		29c. L	icense num	ber		29d. Date signed (Mon	th, Day, Year)
	ا ≽ آ		X Diniet	Lillon K	w.	7	00	5886	50	June 3	0 2006
	10		30. Name and address of person who co			Print)	2222	A) (ALVER	T STREET	,
	Ψ		SHAWN DHILL 31. Date filed (Month, Day, Year)	DN, M.D.			SUITE	222	В	T STREET ALTO, MD	21218.
	Sta Regist		31. Date filed (Month, Day, Year) 4	32. Register's Sign	K	books	9				

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland		rtment of H		Mental Hygie Reg.	711116	20882
		н	Decedent's Name (First, Middle,	Last)		•		2. Date of Death		3. Time of Death
	Physici /Medic		Eugene	Dunn				June &	38, <i>3</i> 00	06 8:15 AM
	Examin		4a. Facility Name (If not institution,	man f		0 . 11.	Location of Death		4c. County of Dea	ath
			644 E. 36th 5. Social Security Number	St. 3. Sex 7. Age (In yrs. It	ast hirthday)	Oultin If Under 1 Year	OPE If Under 24 Hrs.	8 Date of Birth	NA	rthplace (State or Foreign
	Funeral Director		202-22-9721	12M 2DF 7	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	1931 Poi	nnsylvania
20	D.		Usuat Residence of Decedent		-			7	130.101	
	arylar show	Ĕ	10a. State 10b. County		, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	ecto	MD Baltim	ore 1000	son	10f. Zip Code		100	Citizen of What C	
	death with the Maryland rms 23a or 28a-f show r.must be notified at	宣	50 Ashlar H	ill Ct.		21234		us		, out in y s
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of H	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Wh	
õ	or Its	y Fu	1 Never Married 2 Marrie	d 1 7es 2 No		Yes 2 No	Specify:	rriodri, etc.)	Specify: n	10 al
200	hours tural',	Completed by	3 Widowed 4 Divorced	Year or Dates:	16a Deced	ent's Usual Occup	ation	161	b. Kind of Business	IUCK e/Industry
Ċ	nin 72 n "ns Madic	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed)	(Give life. L	kind of work done of OO NOT use retired	during most of work f)	ang	. Talle of Desires.	a modestry
7	giene er the	Com	12+h	57	Admi	nistrato)r	Sc	hool Sy	stem
and	ould be filed within 72 hours after Mental Hygiene. arked other then "natural", or Ita attic event, the Medical Examena	Be	17. Father's Name (First, Middle, L	ast)		A Company		e (First, Middle, Mai	den Sumame)	
7	hould d Men marke natic	2	19a. Informant's Name/Retationshi	n (Type Print)	19b Mailin		Mamie	JONES al Route Number, Ca	ity or Tourn State	Zin Code)
Z	th an treur		Fugenia Doni	els	50 A	shlar H	ill Ct.	Towson	man al	234
ē,	s 1 ar		20a. Method of Disposition		ace of Dispos	sition (Name of natory or other place			. Location - City o	
Ē	Page nent o ant: If ury or		1 Suriat 2 ☐ Gemation 3 4 ☐ Donation 5 ☐ Other (Spe	I Hemoval from State -		,	IA. 7-5	-06 Du	ings m	ills, mo
Saitimoi	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itams 23a or 28a-1 show any injury or other treumstic event, the Madical Examiner must be notified at anone.		21. Signature of Fineral Service L		22	. Name and Addres	ss of Facility		,	21229
_	₫ Ω E = 0		JV4// //	complications that caused the death	Gar	y P. Marc	ch FlH 29	to Fredhill	on Pass	Balto. mo
	ą.		shock or lear faiture. List o	nly one cause on each line.				or respiratory arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. LIVES Due to (or as a consequ		ANCIE	2/			
	Examiner		Conventially first appointmen	h						
-	ν ±	Iner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):					
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequ	ience of):					
8/00,	cate be executed physician and the burial-transit	alE		200 10 (01 20 2 00110040	101100 017.					
200	ificate g phys as the	edical		d						
ZOZ	death certifi e attending id for use as	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnal		Ectopic pregnancy			23d. Date of de	,
о С	wrequires that the death certific been signed by the attending f should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Month	Day Year					
r.	hat the od by the detache			s contributing to death but not resu	23e. Did tobac	co use contribute (ute to the cause of death?			
g,	signe d be o	d by	DEMI	- 111	1 ☐ Yes	_	3 Probably 4 Unknown			
Records	w requirements	lete						24a. Was an	24b. Were a	autopsy findings available
Ž	sician: The taw requires that s certificate has been signed b lirector, page 2 should be deta	Completed						autopsy performed	<pre>1? _ death?</pre>	autopsy findings available completion of cause of s 227No
VII	ian:] rtifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)	NO TO THE	5 22 110
> 	iding Physician: th. : After this certifica funeral director, p	To	1 ☐ Yes 2 ☐ No		ER/Outpatien		4 Nursing Ho	ome 5 Residence		ecity ospice
	ling P. After 1 Junera	lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c, Injun Work	k?	28d. Describe how i	njurý occurred	
UNISION	death ctor: y the t	ficat	2 ☐ Accident investigated investigated Accident investigated a ☐ Could not be a few few few few few few few few few few	ot be	me farm stre		Yes 2 □ No	28f. Location (Stree	t and Number or F	Rural Route Number
2	after after Dire	Certification:	4 Homicide determin	building, etc. (Specify)	ou, addry, onloc		City or Town, S	tate)	
	ospitu hours unera ly fille		29a. Certifier 1 Certifying	Physician: To the best of my know xaminer: On the basis of examinat	wledge, death	occurred at the tin	ne, date and place,	and due to the cause	e(s) and manner a	as steted.
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	onej	and manner stated.						
	5 1 1 5 P	-	29b. Signature and title of certifier	M 6 ho		29c. License	o CC	290.	Date signed (Mon	
	XX		30 Name and address of alcons	no completed cause of death (Item	23a) (Tune	Print)	1370	16 6	1 4/20	006
	J'		GANS	MO Ro MIN	A	3/20 /	INA	~ PAI	KDRI.	VE BALTTY
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	1-0-		I. I. I		- / - /
	Registr	ar	JUL 0	2006 Melus	St. Je	DEMES!				

			For Stata Registrar	State of Man		epartment of H Certificate of I			iene _{og. No.} 200	6 20883				
			1. Decedent's Name (First, Middle, Las					2. Date of Death	h Day Yea	3. Time of Death				
	Physicia /Medic		Phyllis Mari	e Dull				July	3, 2006	6:00 A M				
7	Examin		4a. Facility Name (If not institution, give	•			Location of Death		4c. County of Death					
			6910 Birdwood A				le River	a Data of Birth		imore				
	Funeral Director		5. Social Security Number 6. Security Number 1	7. Age (/ □ M 212 F 5	n yrs. last birtl G	Months Days	Hours Min.	8. Date of Birth (Month, Day NOV • 24	, Year 949	Birthplace (State or Foreign Country) PA				
	pu 🛾	}	Usual Residence of Decedent 10a, State 10b, County	11	Oc. City, Town	or Location				10d. Inside City Limits				
	Aaryla et et	ъ	Maryland Baltimo		•	Middle Rive	h			1 ☐ Yes 2 🂢 No				
	the h	Director	10e. Street and Number	rte		10f. Zip Code		11	0g. Citizen of What	Country?				
	3a or	<u> </u>	6910 Birdwood	Avenue			21220		U.S.A.					
	death me 2	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of H If Yes, specify Cuba		ecity Yes or No-	14. Race - A Black, W	merican Indian,				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hyglene. Important: If Item 27 Ie marked other than "natural", or Iteme 23a or 28a-f ehow important: If Item 27 Ie marked other than "natural", or Iteme 23a or 28a-f ehow appring or other traumatic event, tra Medical Exacilinar must be notified at ances.	<u>چ</u>	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:	nicari, etc.)	Specify:	white				
21215-0036	2 hou	Completed	15. Decedent's Ed (Specify only highest gra		16a.	Decedent's Usual Occup (Give kind of work done	ation		16b. Kind of Busine					
2	e.	op de	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retired	1)	L.	Baltimore Public Scl					
2	ed wi	S		4		Executive S				TOOLS				
Maryland	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last) Francis Stein				18. Mother's Nam		ZZO					
<u> </u>	should ind Men marke umatic	ဠ	19a. Informant's Name/Relationship	Tune Print)	19h	Mailing Address (Street				a Zin Coda)				
Z	d 2 si th an th an traur			usband)		910 Birdwood			-					
	1 and Heelth tem 27 other tr		20a. Method of Disposition		20b. Place of	Disposition (Name of			20c. Location - City					
ē	Pages nent of I int: if it		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			v, crematory or other place W Crematory	1	2006	Baltimore	, Maryland				
Baltimore,	permit. Page Department i Important: If eny injury or	19	21. Signature of Funeral Service Licen		6	22. Name and Addre	22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore. MD 21236							
	du 3 e d		23a Part Enter the disease or com-		Approximate									
		shock, or heart failure. List only one cause on each line.												
	Physician /Medical		Immediate Cause (Final diseases or condition resulting in death) a. Metas tatic addisor Gavanoma Zmoy H Due to (or as a consequence of):											
П	Examiner													
		je.	Sequentially list conditions, if any, leading to immediate											
16	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
O.	cate be executed physicien and the burial-transit		resulting in death) Last	Due to (or as a d	onsequence o	of):								
8760,	ate be hysici the bu	dlcal	•	d										
9	ertific ding p		IF FEMALE:	23c. If yes, outcome of	Dregnancy				004 0-44	4-6				
Box	The law requires that the death certifi tie has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		23d. Date of Month	Day Year				
P.O.	the de	yslo	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown		o in our (appearly)								
	thet hed by deta	by Pt	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying cause giv	en in Part I.	23e. Did tol	bacco use contribut	e to the cause of death?				
rds	quires n sign							1 □ Ye	es 212No 3□	Probably 4 Unknown				
of Vital Records,	law requires been so 2 should	Completed						24a. Was a autops	n 24b. Were	autopsy findings available to completion of cause of				
Ä	The late he	E						perform		1?				
ita		Be C	25. Was case referred to medical examiner?				26. Place of Deat	th (Check only on						
>	S 5	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 🗆 ER/Out		4 Nursing H		ence 6 □Other (5	Specify)				
0 0		ë	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	(ear) 28b. T	njury Wor		28d. Describe ho	ow injury occurred					
Sio	ten leat tor: the	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		At home to		Yes 2 □No	29f Location (St	treat and Number o	r Rural Route Number,				
Division	P # F ∈	Certification;	4 Homicide determined	building, etc.		rm, street, factory, office		City or Town		nulai noble Nolliber,				
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical		nysician: To the best of miner: On the basis of e and manner state	xamination and									
	To the within To the compl	Me	29b. Signature v d title of certifier	los des	y no C	M D 29c. Licens	se number	2	29d. Date signed (M	Conth, Day, Year)				
	10		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type, Print)	101		01-0					
	10		EVAN GELOS	LIGNOS	1801	YORK R	a 5+ 10	12, Tou	usod, p	11,21204				
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUL 0 5 2	32 Registrar	s Signature	YORK R		į						
				0										

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician July 1, 2006 Nina Naomi DeRosa 8:40 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Manor Care Ruxton Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth September 19, 1931 West Virginia **Funeral** 1 ☐ M 2 ☐ XF 74 218-26-5512 Director Yrs Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Mary land Baltimore Towson 1 ☐ Yes 2X No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Airway Circle #4C 21286 USA filed within 72 hours after death "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: if item 27 is marked other that sny injury or other traumatic event, that ance. Crossing Guard Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Boyd Chumley Vada Greathouse ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa L. Leilich/Daughter 3 Airway Circle #4C Towson Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Most Holy Redeemer 7/5/06 Baltimore Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton Leonard J. Ruck, I 5305 Harford Road Inc Baltimore Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certiticate be executed -transit attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 morths? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been si should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 | Inpatient Other: Medical Certification: To 1 🗌 Yes Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA this within 24 hours atter death.

To the Funeral Director: Atter thi completely tilled in by the funeral 27. Mant f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 □ Yes 2 □ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 413106 Registrar's Signature State 5 2006 Registrar 0

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 20885 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 28, 2006 **Physician** Joseph Anthony Ena 6:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Manor Care Ruxton Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Day, July 16, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 1 X M 2 ☐ F **Funeral** Months Days Hours Min 79 Mary land 215-22-7889 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d, Inside City Limits 28e-f show treumatic event, the Medical Examiner must be notified at Maryland Baltimore Towson 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 1310 Dulanev Vallev Road USA or Items 23e Towson Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. e filed within 72 hours after de la Hygiene.
I Hygiene.
other than "neturel", or Item Black, White, etc. Never Married 2 Married Specify. White Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiens Importent: If item 27 is marked other tha any injury or other treumatic event, Ins. 2008. Polishing Department Technician Eastern Stainless Steel 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anthony J. Ena Agatha M. Santoni 19a. Informant's Name/Relationship (Type, Print)
John A. Ena/Brother 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2922 Bristol Channel Court Pasadena Maryland 21122 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Most Holy Redeemer 7/3/06 Baltimore Maryland 4 □ Donation 5 □ Other (Specify) Christina L. Hilton 22 Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee Chustina 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SOFT Physician rissue disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed as the burial-transit Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 11 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Norsing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Hospitel or Attending 1 Aatural To the Hospitel or Attending within 24 hours after death.
To the Funerel Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🕒 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6-29-06 CU Dio. 40054424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cyrus Asadi, 20 E. Timonium pel, suite 209 Timonium, MD 21093 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar JUL 0 5 2006

DHMH 17 Rev 1/200

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death , Day, Y JULY 2\ps **Physician** MARY LOUISA FENNEKOHL 12:13 M /Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4a. FBilly Name (If not institution pive Media Cair Center Examiner If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 82 MaryTand 1 □ M 2 🛣 F 212-20-3605 Director Usual Residence of Decedent the Maryland 10c City Town or Location 10d. Inside City Limits 10a State 10h County other then "neture!", or iteme 23a or 28a-f ehow vent, the Medical Examiner must be nutified at Parkville Baltimore 1 ☐ Yes 2 No MD Director 10f. Zip Code 21234 0e. Street and Number 3200 Acton Road 10g. Citizen of What Country? USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Republic Van Lines Elementary/Secondary (0-12) College (1-4or 5+) Office Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Marie Tagg Albert L. Tagg ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3200 Acton Road-Parkville, Maryland 21234 19a. Informant's Name/Relationship (Type, Print) Stuart Fennekohl-spouse 20c. Location - City or Town, State
Parkville, Maryland 20b. Place of Disposition (Name of 20a. Method of Disposition Parkwood to Cemetery 7-7-06 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 8800 Harford Road-Parkville, Maryland 21234 andral tadder Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEVERE TRANSFUSION DEPENDENT MYELODYSPLASIA **Physician** /Medical KLEBSIELLA SEPSIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner nding physicien and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No 1 Tyes 1 ☐ Yes 2 📉 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 📆 No this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Description Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) mella mo D 41410 NUL 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 MEHTA M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0 5 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 08 20PM 2006 Doris Marie Flavin UNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BACTIMORE HUSP If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yea 8–15–1934 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 M 2 X F 71 Maryland 218-28-6781 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If itam 27 is marked other than "natural", or Itama 23a or 28a-f ahow any injury or other traumatic avent, the Macical Examinating Italian at once. 10a, State 10b. County 1 ☐ Yes 2 ☑ No Funeral Director MD Baltimore Lansdowne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 103 Second Avenue U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify: White Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Spencer Alvey Goldie Hartlove 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Flavin, Jr./Husband 103 Second Avenue Lansdowne MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 12⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial □Donation 5 □ Other (Specify) July 5, 2006 Elkridge, MD 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 ture of Funeral Service Approximate Interval Between Onset and Death 23a. Part. Enter the disease, shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician LUNG DISEASE YEAR END STAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day detached for 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 1 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 🖾 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number JUN 302006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL GOOLATON AVE, BALTIMORE, MD CHANDRA BOMMA MD STAGNES 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

-LAVIN, DORIS MAKI

George Daniel Field Please Type or Print in Black Indelible Ink 06-04529 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1- For State Registrar Deceoent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 0518 hrs **Medical Examiner** George Daniel Field June 28, 2006 4b. City, Town, or Location of Death 4c. County of Death N/A 4a. Facility Name (if not institution, give street and number) Baltimore 405 South Pulaski Street If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 214-62-6533 1 X M 2 F Director Mar. 21, 1954 Country) 52 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location any 10a. State 1 X Yes 2 No Baltimore City 28a-f show N/AMD hours after death with the Maryland 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21230 United States 2130 Maisel Street items 23a 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11, Marital Status 12. Was Decedent Ever in U.S Armed Forces? White, etc. 1 Never Married 2 Married 1 X Yes 2 0. 4 Divorced If Yes, Give Year 973-1975 1 Yes 2 X No specify: White Baltimore, MD 21215-0036 pernit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: I fitem 27 is marked other than "natural", injury or other trannancie event, the Medical Examiner. 3 -- Widowed ۾ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Cook Restuarant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jo Ann McKinley Daniel Wilson Field Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 42 Pacific Blvd., Hedgesville, WV 25427 Jo Ann Craig - Mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition West Arundel Crematory 6-30-2006 Burial 2 X Cremation 3 Odenton, MD Donation Other Specify 22 Name and Address of Facility Ambrose Funeral Home, Inc. Funeral Service Li 328 Sulphur Spring Rd., Arbutus, MD 21227 d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Enter the disease, or complications th **Physician** Between Onset and failure. List only one cause on each line /Medical Death Narcotic intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical item#23a,PII,27,28a-1,penME,g85/,//15/06 TI UNPENDED AMENDED attending pliysician or use as the burial Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by þ 1 Yes 2 No 3 Probably 4 V Unknown Cocaine use Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has uneral director, page 2 sl performed death? Yes 2 V No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death 25. Was case referred to medica 26 Place of Death (Check only one) Division of Vital Be examiner? Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 V Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 1 Yes 2- No 5 Pending Director: d in by the f Fnd 6/22/2006 Fnd 5:00 am ımk 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be in 24 hours
the Funeral Directory Suicide Baltimore. MD S. Pulaski Hwy determined (Specify) Found: other (scene) 4 Hamicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) and manner stated. 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. June 28, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrat Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** James P-R Finlayson 2006 9:45 PM July_ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 1**™**M 2□F Months Days Hours Yrs. Director 1922 Washington, D.C. 577-24-1949 84 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Montgomery Bethesda Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6029 Grosvenor Lane 20814 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after 1 MYes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ♥ No δ Specify 3 ☐ Widowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Concierge Housing Pages 1 and 2 should be filed w from tof Health and Mental Hygie tant: If Item 27 Is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ernest Alfred Rilev Sarah Holt Park 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other traignes. Florence A. Finlayson/ Sister 6029 Grosvenor Lane Bethesda, Maryland 20814 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery July 7, 2006 Brentwood, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Fun ral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Methicillin Resistant Staphyloccus Aureus Infection 4 Days /Medical Due to (or as a consequence of) Examiner Line Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien and s the burial-transit End Stage Renal Disease Due to (or as a consequence of) P.O. Box 68760 Physician/Medical use as the attending | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ cate hes been signage 2 should b 1 Yes 2 No 3 Probably 4 X Unknown Perpheral Artery Disease Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery Disease autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Director: After this certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medicai Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l or A 4 Homicide To the Hospital within 24 hours e To the Funsral Completely filled in Hospital filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) us, D37891 July 2, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amit Kajvanshi, M.D. 121 Congressional Lane # 409, Rockville, Maryland 20852 32. Regis 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 5 2006 Registrar

9:45

7/11/06

FINLAYSON, JAMES, P

			1 - State Amend Item	State o 23a per	of Maryl dr.,G	and / De 857,0 7	partment of F 205/06dhb Pertificate of	lealth and <i>Death</i>	Mental Hy	giene Reg. No.	200	6	20890	
			1. Decedent's Name (First, Middle, L	ast)					2. Date of D Month				3. Time of Death	
	Physici: /Medic		ALICE GRIGE			JUNE	30	20 20		61-50 PM				
	Examin		4a. Facility Name (If not institution, g	ath	4c. (County of D	eath							
			UNIVERSITY OF MAI								N/A			
ı	Funeral Director		5. Social Security Number 6. 214 20 6845	Sex 1 □ M 2 □ F X	7. Age (In)	yrs. last birthe 3	Months Davs	If Under 24 H Hours M	in. (Month. D	rth a <i>y, Year)</i> 4 , 192		Count	ace (State or Foreign ry) ROLINA	
	pu >		Usual Residence of Decedent 10a. State 10b. County		100	. City, Town o	or Location					10	d Jacida Cib. Limita	
	shov	or			100							10	d. Inside City Limits 1 ☐,Yes 2 ☐ No	
	28a-f	Director	MD N/A			BALT	IMORE 10f. Zip Code			10a Citiz	ten of Wha	Count	X	
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	me 23	Funerai	11. Marital Status	12. Was Dec	edent Ever	in U.S.	13. Was Decedent of H	lispanic Origin?	(Specify Yes or N		4. Race - A			
215-0036	n 72 hours after death with the Maryland "naturel", or Iteme 23a or 28a-f ehow idical Experiment must be notified at	by	1 Never Married 2 Married 3 Wildowed 4 Divorced	Armed F 1 ☐ Yes If Yes, G Year or (2 DXNo	W 1995	If Yes, specify Cub. 1 ☐ Yes 2 💆 No	Specify:	erto Rican, etc.)		Black, V SpecifyB]	_		
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<u>=</u>	d 2 should th and Men (7 is marke) treumatic	٦	19a. Informant's Name/Relationship			19b. N	Mailing Address (Street				Town, Star	e, Zip (Code)	
	12 ha		TERESSA GRIGG	S (DAUG	SHTER) 22	47 E. CH	ASE ST.	BALTO	MD.	2121	3		
ē,	s 1 and of Healt Item 2		20a. Method of Disposition		20	b. Place of D	isposition (Name of crematory or other place		Date	20c Loc	cation - City		vn, State	
Ē	Pages nent of ant: If It ary or o		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		State	-		медека	Y 10,20	CI	ROUNIS	VI	LLE,MD.	
Baltimore,	permit. Pages Department of Important: If Its any Injury or o		21. Sign ture of Funeral Service Lice	11	1		22. Name and Addre	ss of Facility B. SCRU	JGGS FUI					
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	D #	ner	Sequentially list conditions, in any, leading to immediate cause. Enter Undertying Cause (Disease or injury											
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C.	/							+		
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89		edical		d										
O. Box	that the death certified by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of deli Month			
7	s that ned by deta	by Ph	Part II. Other significant conditions	contributing to c	leath but not	resulting in th	ne underlying cause giv	en in Part I.	23e. Did	tobacco us	se contribut	e to the	cause of death?	
Z	w requires been sign should be								_ 10	Yes 2	(No 3□] Proba	bły 4 ∐Unknown	
Hecords,	sicien: The law requires that the certificate hes been signed by th rector, page 2 should be detache	Completed				<u> </u>			24a. Was		prior death	to com	sy findings available pletion of cause of	
Vita	ysician: is certifica director, p	BeC	25. Was case referred to medical examiner?					26. Place of D	eath (Check only	-/1				
<u>o</u>	> 0 D	To I	1 ☐ Yes 2 No				atient 3 DOA Oth	4 🗆 IVUISING	Home 5□Res	idence 6	Other (S	Specify)		
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DIVISION	r Attending er death. rector: After by the fune	ficat	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	ho	e of Injury -	At home, farm		Yes 2 □No	28f. Location	Street and	Number o	r Rural	Route Number,	
2	F 9 F C	Certification:	4 Homicide determine	build	ling, etc. (Sp	ecify)	, street, factory, office		City or To	wn, State)			osio (vambo),	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in I	Medicai	29a. Certifier (Check only one) Certifying F	aminer: On the t	e best of my pasis of exam mer stated.	knowledge, on mination and/o	death occurred at the tir or investigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) a date and p	and manne place, and	r as sta due to t	ted. he cause(s)	
	To the within To the comp	W	29b. Signature and title of certifier				29c. Licens				signed (M			
			30. Name and address of person wh	o completed cau	se of death	M.D. (Item 23a) (T)	/ρe, Print)	17410		70	NE 3	5,2	006	
			ANDREN DORSCH	1 01	MC	22 5	GREENE	ST. B	ALTIMORE	MA	RYLAN	クタ	21201	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 5 2006	Morres 1	negistrar's S	ignature	e e							

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State of Maryland / Department of	Health and Mental Hyglene/	U	U	\Box
		-	-	169

For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Doris LaVerne Geisler JUL 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Baltimore <u>Union Memorial Hospital</u> | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Mar. 24, 1925 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Mary Land **Funeral** 220-36-9083 1 ☐ M 2 💢 F 81 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other then "naturel", or items 23s or 28s-f ehow traumatic event, the Modical Examinar must be notified at 1 Yes 2 No by Funeral Director Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Unites States 21230 1321 Webster Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2√√No If Yes, Give A A Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify: White 3XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 9 vears College (1-4or 5+) Π/a King Syrup Machine Operator years permit. Pages 1 and 2 should be fite Department of Heelth and Mental Hy Important: If Item 27 is marked other any liquy or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emma Demming Sherman Wood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Claudia Leichling (daughter) 500 Cresswell Rd Baltimore, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Pk. | 7-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7-2006 | 17-7 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Suna ure of Fune of Serve I censee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 130 E. Fort Ave. Baltimore, MD 21230 J. Wayne Osterling 3a. rtl. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Physician Ischemic Cardiomyopathy /Medical Due to (or as a consequence of): Examiner enns Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Hyperten sion ears and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: After this certificate hes been si completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 10 24a. Was an autopsy performed? 1□ Yes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 DNatural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AT2438946 m.D oon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) at Memorial Hospital. 500N M. CHUNG M.D. Union 31. Date filed (Month, Day, Year) JUL 0 5 2006 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 625AM 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death If Under 24 Hrs. 6. Sex If Under 1 Year 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Pay, Months Days Min 213 \$21\$ M 2□ F Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1XXYes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Light Street Apt. 811 21230 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ ₹₹ No If Yes, Give ↑ ↑ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify. White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fire Brick Layer llyears n/a Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stanley Greif Gertrude Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn E. Greif (wife) 600 Light St. Apt. 811 Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 7-7-2006 Baltimore, MD 21. Sign tute a Fune al Service Licensee McCully -Polyniak Funeral Home, p.A. 130 E. Fort Ave. Baltimore, MD 21230 Wayne Osterling art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he at failure. List only one cause on each line. Approximate Interval Between Onset and Death line iate Cause Final disea a condition any resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9. Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🚮 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed?

Physician /Medical Examiner

Physician

/Medical

10a. State

Examiner

Funeral

Director

28a-f show

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and Mental I

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permit. Pages 1 Department of H Important: If its any injury or ot once.

Director

To Be Completed by Funeral

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

other traumatic event, the Madical Examiner must be notified at

Examine for use as the burial-transit Medical Certification; To Be Completed by Physician/Medical been signed by the a should be detached f within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to completely filled in by the funeral director, page 2 to completely filled in by the funeral director.

or Attending Physician: The law requires that the death certificate be executed

the Hospital

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital:

1 Yes 2 No 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

1 Natural 2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be

determined

1 npatient 28a. Date of Injury (Month, Day Year)

Other: 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No

4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

29d. Date signed (Month, Day, Year)

Me

31. Date filed (Month, Day, Year)
JUL 0 5 2006

Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 17 19a per fh 8857 7-5-06 yt.
State of Maryland Department of Health and Mental Hygiene 2 0 0 6 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death . Month 5:55 PM 2006 June Gardner Mae 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Agnes +OSPI+a re +im0 Dain. a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 09 30 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 □ M 2 XF Hours NC 86 219-18-1568 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 No NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2814 Windsor Ave 21216 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: Black Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry Baltimore City 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Public Schools 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown George McClain Goldie Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gardner 21216 2814 Windsor Ave, Baltimore, Md Gardener-Son Henry 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Deprial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) King memorial Park 7/6/06 Randallstown, Md 21. Signature of Funeral Service Licensee 22 Name and Address of Facility MARCH F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1 Enter the flishase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia days Due to (or as a consequence of): day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) e men that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

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Director

Funeral

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Completed

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r than "neturel", or Items 23s or 28s-f show the Medical Exeminer must be notified at

I Hygiene.

12 should be filed w h and Mental Hygier 7 is marked other th

Pages 1 nent of H ant: If ite

ō permit. Page Department Important: If any injury or once.

Baltimore, Maryland 21215-0036

Box (

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Records,

Division of Vital

Examiner signed by the attending physicien and of defacted for use as the burial-transit by Physician/Medical certificate has been s rector, page 2 should Completed 2 Certification: l or Attending after death. Il Director: Af filled in by

IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

performed 1 Yes 2 X No 26. Place of Death Check only one

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

3 ☐ Suicide

29a Certifiar

4 - Homicide

27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 Could not be determined

JUL 0 5 2006

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

aniel Abraham 18609

June 29 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abraham 31. Date filed (Month, Day, Year)

900 32. Pegistrar's Signature

Caton Ave, Baltimore, MD

within 24 hours at To the Funeral D completely filled is Hospital

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Medical

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Registrar

State

			1 - For State Registrar Amend Item		aryland / Depa				ene 2006	20894
			Decedent's Name (First, Middle, La	ist)	G031 170.	700 JII -		2. Date of Death		3. Time of Death
	Physicia		A whath	Cotaces	Walter A	A. Grager		June 5	Day Year	C I II D M
	/Medic Examin		4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, or L	ocation of Death		4c. County of Dea	
			Bayview Medic	of centr		Balt	may		Balto	nove
	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bir	rthplace (State or Foreign ountry)
Н	Director		182-14-1762	1፟፟፟፟፟M 2□F 8	S8 Yrs.			June 7,1		nnsylvania
	pug *		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	ocation		T	-	10d. inside City Limits
	Aarylis I sho	ō	Maryland Balt:	imore	,		Edo	gemere		1 □ Yes 24(2XNo
	28a-1	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What C	ountry?
	with Sa or						21210			
	Jeath The 2:	Funeral	2605 Manor Ave	12. Was Decedent 8	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban	21219 panic Origin? (Spe	cify Yes or No-	United St	erican Indian,
ထ	or Ite	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces?	ło		, Mexican, Puerto I Specify:	Hican, etc.)	Black, Whi	ite, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Madical Exercit art Le matified at	l by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWII	1 195 2 NO	эрөспу.		Specify:	White
2-0	72 h	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occupat kind of work done du DO NOT use retired)	ion iring most of workir	ng 16	6b. Kind of Business	s/industry
2	vithin ne. han	m p	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retired)			Chaol Tu	
N	iled v dygie ther t		8 Years 17. Father's Name (First, Middle, Last	1)	Cı	cane Opera	tor 18. Mother's Name	/First Middle Ma	Steel In	idustry
and	ntal hed of	Be						ce Creiq	•	
Maryland	thoute mark matic	은	William Grager 19a. Informant's Name/Relationship		19b. Maili	ng Address (Street ar				Zip Code)
<u>8</u>	od 2 s lth ar 27 ls r trau		Mrs. Debra A. Gi			9 Manor A		mere, Ma		21219
ଦ୍	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examilmet matter and the notified at once.	7	20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place)	D	ate 20	c. Location - City or	Town, State
Ë	Page ent o nt: If ry or	1	MXBurial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Speci					6/24/200	6 Dorsey	, Maryland
Baltimore,	mit.		21. Snature of Funeral Service Lice	Isee /	-	2. Name and Address Ida-Ruck Fi				
m	Departiment of the policy of t		Me ()	.600	1/ 17	922 Wise	Ave. Dur	ndalk, Ma	ryland 2	21222
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not en					Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Film	runt Ron	el E. line				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	120 100				o. Care
E		_	Sequentially list conditions, if any, leading to immediate	b. Card						one manh
	ed sit	ine	if any, leading to immediate Due to (or as a conseq raince of): cause. E.i.va. University Cause (Disease or injury							
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89	ifficate g phy as the									
Вох	death certifica e attending ph ed for use as th	M/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth		Ectopic pregnancy			23d. Date of de	,
Ω.	deat ne att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		Other (specify)			Month	Day Year
<u>Р</u> О	that the de led by the a detached f	Phy	9 Unknown					On Didash		
	signed be det	þ	Part II. Other significant conditions					23e. Did (obac		robably 4 Ohknown
oro	w requir been si should	eted	Change 14 to	Diseas,	competition.	thank to	and the same			
Records,	e fa has	Completed	Despherel U.S	unlan D	Seare			24a. Was an autopsy performe	_ prior to	utopsy findings available completion of cause of
a					,			1 ☐ Yes 2	No 1 ☐ Yes	s 2 No
of Vital	Physician: this certifica ral director, I	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 ER/Outpatie	Other	26. Place of Death		- C DOth/C	
	Phy or this eral d	\vdash	27. Mann of Death	1 De atie 28a. Date of Injur	y 28b. Time o		and the same of th	8d. Describe how	ce 6 □Other (Spe injury occurred	эспу)
ion	Attending or death. ector: After by the fune	ation	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day on	Year) Injury		es 2□No			
Division	Atte ecto by th	iffica	3 ☐ Suicide 6 ☐ Could not I determined		ury - At home, farm, st	reet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or R	ural Route Number,
Ö	tal or	Certification:		Dunding, on						111200 111000
	Hospital or 24 hours afte Funeral Dir itely filled in	ledical	(Check only 2 Medical Exa	hysician: To the best ominer: On the basis of	examination and/or in	h occurred at the time	, date and place, a nion, death occurre	ind due to the caused at the time, date	se(s) and manner as	s stated. e to the cause(s)
	the the	Medi	one) 29b. Signature and title of certifier	and manner sta	ited.	-				
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		110	30. Name and address of person who	completed cause of d	eath (Item 23a) (Tuco	Print)			whe de	-, 2006
	6+1			which will	Bayven 1	redical Cont	2 494	4233 01	um Aner	e Baltime
	Sta	te	31. Date filed (Month, Day, Year)	. Registra	ar's Signature					D, 2006 Baltine
	Registr	ar	JUL 0 5 200	10 Minus	IN Agra	W.				

			For State Registrar	State of Ma		nd / Depa		t of H	ealth a		ental Hy			6	20895	
	Physici /Medio		Decedent's Name (First, Middle, Last) Ellis Thomas Gibson								2. Date of De June 2		2006 Yea		Time of Death 2:00 A _M	
	Examir		4a. Facility Name (If not institution, give s Gilchrist Medical Center	•			T	owson					Baltim	ore		
	Funeral Director		240-14-0709	7. Ag	e (In yrs. 84	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir Month, Da Decembe	th /4ª,	^{9. B}	irthplace	(State or Foreign	
3	death with the Maryland ms 23a or 28e-f ehow f must be notified at	tor	Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore	^ e	10c. Cit	ty, Town or Lo Balt	ocation Imore								nside City Limits	
7	with the a or 28e be not	Direc	10e. Street and Number				10f. Zip	Code 1236				10g. C	USA	Country?		
25/06	늘 프림	by Funeral Director		1 Never Married 2 Married 1 TYYes 2 No WM				lent of Hi		gin? (Spe , Puerto F	cify Yes or No Rican, etc.))-				
3	Maryland ZIZI3-0035 d 2 should be filed within 72 hours at th and Mantal Hygiene. 27 is marked other than "natural", or treumatic event, the Medical Exami	To Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Boilermaker					of working	ng			der & Dry Dock				
1740	VIANG A Suld be filed Mental Hygi arked other atic event,	To Be Co	17. Father's Name (First, Middle, Last) Ellis Gibson						Bessi	ie Bul		, Maide	en Surname)			
	Mar nd 2 sho aith and 27 is m		19a. Informant's Name/Relationship (Ty) Debcrah J. Lusco/Frier			1	-				ne Mary		or Town, State 21236	, Zip Cod	Θ)	
E CH	DAILLINOTE, permit. Pages 1 ar Department of Hea Important: If Item eny injury or othe		20a. Method of Disposition 1 X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)		Par	Place of Disponentery, creative Communication Communicatio	emeter	/	1 7	7/1/06	ate D		Location · City o			
IME	Dant. Departn imports eny inju		21. Signature of Funeral Service Licensee Christina L. Hilton Chattan Afficiant Service Licensee Christina L. Hilton 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore									re Marvland 21214				
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as	M/C a conseq	th. Do not en	ter the mod	e of dying	g, such as o	cardiac or	r respiratory a	rrest,		App	oroximate rval Between set and Death	
212	O& / OU, ifficate be executed g physicien end as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to unmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as												
C C	U. BOX the death cer the ettendin	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	aldeath 3	⊒Ectopic pr ⊒ Other (sp				201		23d. Date of d Month	elivery Day	Year	
	HECOIDS, F.	ted by Ph	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3								_					
	0 0 00	Comple									1 ☐ Yes	psy ormed? 2 Den	prior to death?	o complet	indings available ion of cause of No	
	Jing After fune	ation: To Be	examiner?	examiner? 1						th (Check only one) ome 5 ☐ Residence 6 ☐Other (Specify) Wo SPLC 28d. Describe how injury occurred				معهونو		
	DIVISION To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At h c. (Specii	ome, farm, st	reet, factory	, office		2	8f. Location (City or To		and Number or i	Rural Rou	ite Number,	
	the Hospital or hin 24 hours afte the Funeral Dir npletely filled in	Medical	29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medical Examination)	sician: To the best ter: On the basis o and manner st	f examina	owledge, deat ation and/or in	th occurred nvestigation	at the tim in my op	e, date and pinion, deat	d place, a h occurre	and due to the ed at the time,	cause(date a	(s) and manner and place, and di	as stated. ue to the	cause(s)	
	To the within To the comp	Ž	29b. Signature and title of certifier	ns				License		3		29d. D	Ne 28	nth, Day, 20	Year) O.C	
	8		30. Name and address of person who co	LUES. U	N	66001		Cl	route	5 5	+ PSV8	nst	Ne 28	no	21204	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 5 200	37 Registr	ar's Signa	ature	andi)									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 July 2, **Physician** Lester J. Gottlieb 12:30 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Year) July 24, 1921 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min 1⊠M 2□F Yrs. 84 068-12-9668 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28e-f show 10a. State 10b. County 1 ☐ Yes 2X No Silver Spring Maryland Prince George's Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r then "natural", or iteme 23a or the Medical Examinar must be 3148 Gracefield Road CL-415 20904 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any jury or other traumatic event some. 17. Father's Name (First, Middle, Last) Be Abraham Gottlieb Helen Gamsey 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn B. Gottlieb/Wife 3148 Gracefield Rd., CL-415, Silver Spring, MD 20904 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Montgomery Crematorium, Inc. July 5, 1 □ Burial 2 ☑ Cremation 3 □ Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2006 Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 21. Signature of Funeral Septice Licensee M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Right Femoral Neck Fracture 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Parkinson's Disease Urinary Tract Infection 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? certificate arricia 1 Yes 2□ No 1 ☐ Yes 2X No 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 ⊠Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1⊠Yes 2 No 2 ER/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; s after decrei Afr 1 Natural 5 Pending Fell while trying 1 ☐ Yes 2 X No investigation 6/26/06 3:00 PM 2 X Accident to get up. 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Renaissance Gardens 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Nursing Home Riderwood Village, Silver Spring, MD within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 29c. License number D23649 July 2, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Stuckey, M.D. 3110 Gracefield Road, Silver Spring, Maryland 20904 32 Registrar's Signature 31. Date filed (Month, Day, Year) Goods State JUL 0 5 2006 Si Meras Registrar

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			1 - For State Registrar	Oldie of Mai		ertificate of			eg. No.	06	20897
	120	7	Decedent's Name (First, Middle	, Last)				2. Date of Deat Month		Year	3. Time of Death
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il.	Examin		4a. Facility Name (If not institution,				or Location of Deatl	1	4c. County of Death		
12			1749 REMINGTON 5. Social Security Number		(In yrs. last birtho	CROFTO		9 Date of Righ	ANNE		
Ī,	Funeral Director		214-20-3557	1 M 2 F	80 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, 02/16/	1 926	9. Birthp Cour	place (State or Foreign ntry) MD
			Usual Residence of Decedent					02/10/	1320		
	arylar show	_	MD ANNE	ARUNDEL	10c. City, Town o					1	10d. Inside City Limits
	the M	Director	10e. Street and Number			10f. Zip Code			0g. Citizen of V	that Cour	
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	death ms 2:	Funeral	11. Marital Status	12. Was Decedent Ev	ver in U.S.	3. Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race	e - Americ	can Indian,
9	or Ite	/Fu	1 Never Married 2 Marri	Armed Forces? 1 Tes 2 No If Yes, Give		1 Yes 2 No	an, mexican, Puert Specify:	o Hican, etc.)	Specify	k, White, WH	ITE
9500-61212	hours after death with the Maryland turel', or Items 23s or 28s-f show at Examinan he notified at	Completed by	3 Widowed 4 □ Divorced	Year or Dates:	1 10- 0						
5	within 72 ho ene. than "natur ne Medicel	olete	15. Decedent (Specify only highes	t grade completed)	(G	ecedent's Usual Occup live kind of work done e. DO NOT use retire	during most of wor	king	16b. Kind of Bu	siness/in	dustry
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	al Hygid J other	BeC	17. Father's Name (First, Middle, L	.ast)				ne (First, Middle, M	Maiden Sumam	•	
<u>X</u>	ould to	^o	LOUIS			HIGGER	FANNI				ITNICK
Maryland	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationsh LANA GORDON SCI			alling Address (Street 749 REMING					
	s 1 and f Health ftem 27 other tr		20a. Method of Disposition	•	20b. Place of Di	sposition (Name of			20c. Location -		
Ë	0 0 = =		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ☐Removal from State pecify)	ANSHE	TONAH or other pla		0.40000	41 - 71100		
Baltimore,	permit. Pag Department Important: eny injury c		21. Signature of Funeral Service L	icensee	+ Aliz Ci	22. Name and Addre	ess of Facility SC	2/2006 B L LEVINS	ALTIMUK AN & RD	E, M	T N C
n	82 = 8		Mast Cen			8900 REIS	TERSTOWN	ROAD - P	IKESVIL	LE.	MD 21208
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused to only one cause on each line	he death. Do not						Approximate Interval Between Onset and Death
100	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a. Congesta	reltenu	Failure				3	Weeks
f	Examiner		,		consequence of):					6	Months
¥.	<u>></u> ₩	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Lung C Due to (or as a	consequence of):						10001011.3
	nd A	Examiner	that initiated events	с							
160,	ate be executed hysician and the burial-transit	Ex	resulting in death) Last	Due to (or as a	consequence of):						
289	physic physic the b	dical		d				-			
Box	death certificate e ettending phys d for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date	e of delive	arv
ñ	death e ette	iciai	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at til		3 □Ectopic pregnance 5 □ Other (specify) _	y 		Mor		Day Year
J.	et the by th stache	hys	9 🗆 Unknown	9□ Unknown							
Š,	law requires thet the death certifica as been signed by the ettending ph 2 should be detached for use as th	by	Part II. Other significant conditio				- 1	4			ne cause of death?
Ö	requi	eted	Coronary Artery	CISEAR ANI		2.	100				
Hecords,	sician: The law certilicate has t irector, page 2 s	Completed by	vascular alxase	Diasetes	mellita	15, Chranic	-	autops	y P		psy findings available mpletion of cause of
Vital	an: T	ø	25. Was case referred to medical	se thy parteus	cor mei	anoma U	erine cam	th (Check only on		Yes	2 🗆 No
	> 0 0	To B	examiner?	Hospital: 1 Inpatient	t 2 ☐ ER/Outpa	tient 3 DOA Ott	000	ome 5 Reside		r (Specif	y)
n of	ding Ph th. After the		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Tim Inju		y at rk?	28d. Describe ho	w injury occurr	эd	
SIO	r Attending er death. rector: Atter by the funer	cat	2 Accident investig 3 Suicide 6 Could n	ation of he	***************************************		Yes 2 □No	006 1 (0)			
DIVISION	o te	Certification:	4 Homicide determi	ned 289. Place of Injury building, etc.	y - At nome, farm (Specify)	street, factory, office		28f. Location (St. City or Town	reet and Numbe 1, State)	r or Hura	il Houte Number,
	Hospital or 24 hours after 6 Funeral Direction in letterly filled in		29a. Certifier 1 Certifying	Physician: To the best of	my knowledge, d	eath occurred at the til	me, date and place	, and due to the ca	tuse(s) and ma	ner as st	tated.
	To the Hospital within 24 hours a To the Funeral completely filled	edical	(Check only 2 Medical E	examiner: On the basis of eand manner state	xamination and/o	r investigation, in my o	ppinion, death occu	rred at the time, da	ate and place, a	nd due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	A		29c. Licens			9d. Date signed	(Month,	Day, Year)
•	/		GaraMus	with MD		044	2445		6/2	4/04	0
	12		30. Name and address of person values carich	no completed cause of dea	ath (Item 23a) (Ty	De, Print)	nbritls,	MD 21	0511	,	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar	's Signature	lacel !	merrico,	ا) عن حراب	037		
9.2	Registr	ar	JUL 0 5	2006 dispers	1 15 /	A REPORT OF THE PROPERTY OF TH					

DHMH 17 Rev 1/2001

	•		101	epartment of Health and I Certificate of Death		ene 2 0 0 6	20898
	° Physici /Medic		1. Decedent's Name (First, Middle, Last) CHARLES 7.	HOLMES	2. Date of Death Month JUNE	Day 2 Year 29 2006	3. Time of Death
	Examin Funeral Director		4a. Facility Name (If not institution, give street and number) TOHNS HOPKINS HOSPITA 5. Social Security Number 212-32-6540 6. Sex 1 n N 2□ F 67 Yr	day) If Under 1 Year If Under 24 Hrs.		4c. County of Death N/A 9. Birthpl Count Count 1938 West	ace (State or Foreign W) Virginia
	show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the County 10c. City, Tow			10	Od. Inside City Limits 1
	ith the Mi or 28a-f	Director	Maryland N/A Balts 100. Street and Number 1053 Horners Lane	imore 10f. Zip Code 21205		. Citizen of What Count	
36	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 le marked other then "neturel; or Items 23s or 28s-1 show any njury or other traumatic event. The Modifiel Excludes controlled at page.	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Ke Never Married 2 Married 3 Widowed 4 Divorced Year or Dates:	13. Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - America Black, White, e Specify: Whi	etc.
21215-0036	within 72 hour ene. then "neturel	Completed b	15. Decedent's Education (Specify only highest grade completed) (6	Decedent's Usual Occupation Give kind of work done during most of wor ife. DO NOT use retired) Assembly Line	king	b. Kind of Business/Ind	,
and 2	d ba filed ental Hygia ced othar c event. I	Be	17. Father's Name (First, Middle, Last) Charles Holmes		ne (First, Middle, Mai		
Maryland	nd 2 shoul Ith and Me 27 le mari	To	19a. Informant's Name/Relationship (Type, Print) 19b. N	Mailing Address (Street and Number or Ru 053 Horners Lane, Ba		ity or Town, State, Zip	,
altimore,	Pagas 1 ar ent of Hea nt: If item : ry or other		1 Rurial 2 Cremation 3 Removal from State Cemetery,	pisposition (Name of crematory or other place)	- 1	c. Location - City or Tov	
Baltin	permit. F Departme Importar any njur		21. Signature of Funer Service Licenses	22. Name and Address of Facility McCully-Polyniak Fu	uneral Hom	ne P.A.	
8760, 5	Physician /Medical Examiner itte prutal-transit	dicai Examiner	23a. Art. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of)	SPIRATORY F,	or respiratory arrest, AILURE		Approximate Interval Between Onset and Death 4 hours
.O. Box 6	Tha law requires that the death certific ta has been signed by the attending t oage 2 should be detachad for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver Month	y Day Year
Ф	uires that t signed by Id be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given in Part I.	23e. Did tobac	co use contribute to the	
al Records,		Completed			24a. Was an autopsy performed	prior to com death?	sy findings available pletion of cause of
on of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificata compilately filled in by the funeral director, pag	tion; To Be	25. Was case referred to medical examiner? 1	atient 3 DOA Other: 4 Nursing H	th Check onl one one 5 Residence 28d. Describe how it	e 6 ⊡Other <i>(Specify)</i> injury occurred	
Division	al or Attendi after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural (tate)	Route Number,
	To the Hospital or At within 24 hours after or To tha Funerel Direct completely filled in by	edicai C	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, concept of the basis of examination and concept one)	death occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the caus- red at the time, date	e(s) and manner as sta and place, and due to t	ted. he cause(s)
)	To th withir To th	Me	29b. Signature and title of certifier. AD EWUNMI, 0:	M·b· 59418	29d.	Date signed (Month, D. UNE 29	ay, Year) 2006
	5		30. Name and address of person who completed cause of death (Item 23a) (Ty Oluvania) Adewunmi MD 600 Nov the	holfe St. Baltin	more Mr) 21287	
4	Sta Registr		31. Date filed Month, Payr-Yeg 006 32. Registrar's Strature	uli	· · · · · · · · · · · · · · · · · · ·		

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar		Certifica	ate of	Death				eg. No.	0.0	6 208
Physicia Medical Exami	21117	1. Decedent's Name (First, Middle,Last)	Month Day Year							Time of Death 1445 hrs		
neulcai Exaiiii مراث	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death											
		2406 Fleet Street				Baltimore						
Funeral Director		5. Social Security Number 6. Sex 215-94-5549		yrs. last birtl 40	nday) Yrs.	If Under 1 Year Months Days	If Unde Hours	r 24Hrs. Min.		/1966		place (State or Maryland ntry)
any	-	Usual Residence of Decedent 10a. State 10b. County _	100	c. City, Town	or Locatio	on						10d. Inside City Limits
* .	tor	MD Balti 10e. Street and Number	more			Dui	ndal	.k		0g. Citizen of Wh	1	1 Yes 2 X No
h the Mar 3a or 28a otified at	I Director	7591 Ives Lane				2122				USA		
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f sho marite event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:		If Ye	Decedent of Hisp s, specify Cuban, Yes 2 X No	Mexican,			Specify:	e, etc.	an Indian, Black, ite
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examines	Completed b	15. Decedent's Education (Specify onl Elementary/Secondary (0-12) 12th	y highest grade comple College (1-4 or 5+)		during mo	s Usual Occupation st of working life. Inter-La	DO NOT	use retire		16b. Kind of Bu		·
21215-0036 build be filed within 7 Mental Hygiene marked other than revent, the Medics	Be	17. Father's Name (First, Middle, Last) Daniel Hick					S	hir	lev A.	Maiden Surname Pietr	owsl	۲i
D 21 should and Me 7 is ma	٩	19a. Informant's Name/Relationship (Ty Shirley A. Jack								mber, City or Tow		Zip Code) MD 21222
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental tant: If item 27 is marked or other traumatic event,		20a. Method of Disposition 1 Burial 2 X Cremation 3		20b. Place o		ion (Name of cem	etery,		Date	20c. Location -	City or T	own, State
Baltimore, bermit. Pages I a Department of He Important: If ite		4 Donation 5 Other Specify		Gree	nmoı	ınt			Z006			•
Balt permit. Departu Import		21 Signature of Funeral Service Licens	see		22. Na	ame and Address	of Facility ${ m onkl}$	Jos ina	seph N St.Ba	N/Zanni altimor	no i	Jr. FH 4D 21224
Physician /Medical		23a. Part I. Enter the disease, or complifailure. List only one cause on each	ch line		t enter th	e mode of dying, s	such as ca					Approximate Interval Between Onset and
Examiner			Narcotic into Due to (or as a conseque		n and	cocaine us	æ					Death
	Je.		Oue to (or as a conseque	ence of):							-	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):								
760, frate be executed physician and the burial - trans		dd	AMENDED item	#23a.27	. 28a-f	perME,g85	57.7/6	<u>/06 Т</u>	г			
60, ate be e hysicia e buria	n/Medical	IF FEMALE:	23c. If yes, outcome of		,2011	, , , , , , , , , , , , , , ,	,,,,	700 1.		23d. Date of	delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burit	Physician/	23b Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at tim 9 Unknown	2		al death 3 er (Specify)	Ectopic	pregnand	Э	Month	Da	y Y ear
P.O. E	by Ph	Part II. Other significant conditions	contributing to death bu	t not resulting	g in the ur	nderlying cause gi	ven in Pa	rt I.				e cause of death?
ords, P.C w requires that is been signed be	ted k			<u>.</u>					24a. Was			bly 4 Unknown psy findings available
COF e law re le has be ge 2 sho	Completed								autor perfo 1 ✔ Yes	osy p rmed? d		mpletion of cause of
tal Rec		25. Was case referred to medical				26.Place		(Check on		2 10 1	165	2 NO
Vita hysicis this ce Il direc	To Be	1 Yes 2 No	ospital: 1 Inpatient		utpatient		Other ₄		Home 5	Residence 6	Other: \$	3cene
on of \ ending Phy ath or: After the		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year) Fnd 6/27/20		Time of In 1 2:36		y at Work es 2 X	NI-	8d. Describe	how injury occurre	ed	
Division of Vital Records, ital or Attending Physician: The law requir urs after death ral Director: After this certificate has been silled in by the funeral director, page 2 should b	Certification:	2 Accident Investigatio 3 Suicide 6 X Could not be determined	28e. Place of Injury	- At home, fa	rm, stree	, factory, office bu	uilding, et	c. 2		Street and Number State) 2406 F1	er or Rura Leet S	Route Number, City treet
Division To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Physicia one) 2 Medical Examiner:	an: To the best of my kr On the basis of examin and manner stated.									
Lalo	M	29b. Signature and title of certifier	11/1	L		29c. License O.C.N				June 28, 20		ı, Day, Year)
		30. Name and address of person who co Jack Titus MD. Deputy C	completed cause of deat Chief Medical Example		11 Pen	n Street, Balti	more. I	MD 212	01	1		
	tate	31. Date filed (Month, Day, Year)	32. egistrar's					-				
Regis		JUL 0 5 200	6 Bearing	Fg.	1/201	Es I						
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			1 - For State Registrar	State of Marylan		ent of Health and late of Death	Mental Hygie	6000	20900
	Physici /Medic			ircum			June 3		3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give : Northwest Nospi	761	Ro	ity, Town, or Location of Death		Balt, mor	rt
	Funeral Director		5. Social Security Number 215-70-6690 Usual Residence of Decedent	M 2 F 7. Age (In yrs.	Yrs. Monti	der 1 Year If Under 24 Hrs. hs Days Hours Min.	8. Date of Birth (Month, Day, 16	9. Birthpl Count	ace (State or Foreign try)
	Maryland n-f show	tor	10) State 10b. County H	More 10c. Cit	y, Town or Location	dallSton	on	10	od. Inside City Limits 1 ☐ Yes 2 X No
	ath with the 23a or 28 ust be no	Funeral Director	10e. Street and Number Hensu	Doo Rd.	10f.	Zip Code 21133	10g.	Citizen of What Count	try?
980	72 hours after deeth with the Maryland natural', or tteme 23a or 28a-f show iteal Examinar must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ∐Yes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (S specify Cuban, Mexican, Puert s 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e	
Maryland 21215-0036	within ene. then	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's U Give kind of Jille. DO NO	Isual Occupation work done during most of wor Tuse refled)	tking 16t	Jation Williams Under Suran	de
/land	should be filed ind Mental Hygis is marked other umatic event, it	To Be C	17. Flather Name (First, Middle, Last) Ri Chard (Nay)	man		Valorieris Nar Kobe	ne (First, Middle, Mai		
	and 2 shoul leelth and M m 27 is marl her traumati		19amnformant's Name/Rel tionship M	, Sr./Husband	9060 Al	enswood Rd	11 1 .4		21133
Baitimore			20a. Method of Disposition 1	emoval from State	Place of Disposition (I semetary, cremator)	never 7/8	7/2006 U	Location - City or Town	wn, State
Bail	permit. Page Department of Important: If any Injury or	9 3	21. Signiture of Fune a) Service Ucens	Treene	8729	The Rd.	ne Fune Randalle	stown, Mi	21133
	Pnysician		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition	cations that caused the death e cause on each line. Metastati	R	4 0	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a consequent					227.12
8760,	ate be executed thysicien and the burial-transit	Ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ					
P.O. Box 68	death certific e attending p id for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 952 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of di	I death 3 Ectopic	c pregnancy (specify)		23d. Date of deliver Month	y Day Year
	es the igned be de	ρ	Part II. Other significant conditions con	tributing to death but not resi	ulting in the underlyin	g cause given in Part I.	23e. Did tobacc	co use contribute to the	
Vital Records,	The ate h	Completed					24a. Was an autopsy performed 1 Yes 2	? prior to com death?	sy findings available pletion of cause of
of Vit	this al di	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death		ER/Outpatient 3 28b. Time of	DOA Other: 4 Nursing H		6 □Other (Specify)	
Division of	After After fune	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At ho	Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how in	and Number or Rural	
Ω	To the Hospitel or Attent within 24 hours after deati To the Funeral Director:		4 Homicide determined 29a. Certifier 1 Certifying Phys	building, etc. (Specify	v)	ed at the time, date and place	City or Town, St	ate)	
	To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examir	and manner stated.	tion and/or investigati	ion, in my opinion, death occu	rred at the time, date	and place, and due to t	the cause(s)
(7 3 1 8		Valusut	Physeien	220) (T	never Doportnet	j	rune 30	2006
	6		30. Name and address of person who co	D.O. Northwo	ture	never Daportnest	5401 01d C	ourthood Rank	11/m MD 21133
	Sta Registr		JUL V 5 2	32. Rajistrar's Signa	S. Apar	(e)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Elro Jackson LLIDOAM 07 06 01 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Conter NIA -Care Baltimore Keswick Multi 8. Date of Birth (Month, Day, Year) DT 11 1910 If Under 24 Hrs. 5. Social Security Number 6. Sex If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X**M 2□ F Months 95 116-09-7618 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show th and Mental Hygiene. ?7 is marked other then "neturel", or Items 23e or 28e-f show treumetic event, the Medical Examinar roust be notified at 1 No Yes 2 No MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 21206 Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 28 Yes 2 ☐ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 S-No Specify: Specify: Black à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Naval Base aborer 7th arade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard Jackson Susie Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Importent: If item 27 is
any injury or other treu Crowder NIECE Mildred Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hampton Memorial 07/07/06 Hampton ' 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
22 Name and Address of Facility
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29 Name and Address of Facility
20 Name and Nam 21. Signature of Funeral Service Licensee Funeral Services to moisles 23a. Part r. Enter the disease, or a implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** an /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): attending physician for use as the burial Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ٩ 1 🗌 Yes 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; or Attending 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 - Homicide To the Hospitel completely filled 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (Item 23a) (Type, Print) Charle St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 05 2006 Registrar

VOID

CERTIFICATE

2006-20902

SEE

CERTIFICATE #

2006 - 18673

DelRoy Jones

or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: A completely filled in by the fu death. To the Hospitel

Physician

/Medical

Examiner

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itam 27 is marked other then "naturel", or items 23s or 28s-f show other traumstic event, the Madical Exactions must be nutified at

permit. Pages 1 and 2 should be filed within 72 hours after Depertment of Heelth and Mental Hygiene important: if itam 27 is marked other then "naturel", or its may highly or other traumatic event, the Medical Examining and

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

death with the Maryland

DHMH 17 Rev 1/2001

State Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c	k Throm	1BOS LS		MONN
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy er (specify)		23d. Date of del Month	ivery Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
HYPERTENS	ION		1 ☐ Yes	2 □ No 3 □ Pr	obably 44 Unknown
/1			24a. Was an autopsy performed?	death?	topsy findings available completion of cause of
25. Was case referred to medical examiner?			ath (Check only one)		
1 ☐ Yes 2 € No	Hospital: 1 Inpatient 2 □ ER/Outpatient 3	□ DOA Other: 4 □ Nursing H	lome 5 Residence	6 □Other (Spec	cify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28c. Injury at Work?	28d. Describe how inj	ury occurred	
3 Suicide 6 Could not be 4 Homicide determined		actory, office	28f. Location (Street a City or Town, Sta		ral Route Number,
29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	nysician: To the best of my knowledge, death occuniner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place lation, in my opinion, death occu	e, and due to the cause(rred at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Monti	h, Day, Year)
JAT 120U	eurn	05036	JUI	14/2	206
	completed cause of death (Item 23a) (Type, Print)	LPC, B.	WLIIM	unt 1	MD 21205

2006 5

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State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician July Djamalieh Rouhani Karimian 2006 ĭ 4:50 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore County If Under 1 Year If Under 24 Hrs. Months Days Hours Min (Month, Day, Year) NOV • 10 , 1935 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F 218-17-3476 70 Director Usual Residence of Decedent filed within 72 hours after deeth with the Marylend Hygiene. 10b. County 10c. City, Town or Location r then "naturel", or items 23a or 28a-f ehow tre Medical Examinar must be notified at 10d. Inside City Limits Maryland Baltimore County Cockeysville 1 ☐ Yes 2 ☐ No Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Hometown Way 21030 Iran Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify:Iranian Baltimore, Maryland 21215-0036 Specify If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) N/A Education Elementary School Teacher marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental F 7 is marked of Ali Rouhani Tahereh Rouhani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Jonathans Court Hunt Valley, Maryland, 21030 Mr. Ken Karimian (Son) if item 27 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: if its eny injury or of once. 1 ☑ Bunat 2 ☐ Cremation 3 ☐ Removat from State Dulaney Valley Mem. July 5,2006 Timonium, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funerat Service Licensee Péaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** AS No menth /Medical Due to (or as a o nsequence of) Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner led by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical **tF FEMALE** 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed b Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No this certificate 1 ☐ Yes director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA After the 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide in by 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter To the Funerel Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 1092902 no completed cause of leath (Item 23a) (Type, Print) N. Charles St. R BMC 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 00:58 M **Physician** Valitan Howard Knight, Sr. 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SINAI HOSPITAL OF BALTIMORE BALTIMORE CITY If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 02.17.1938 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 15M 20F 68 Yrs. MD 212.34.0407 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at ORCE. MD 1 XYes 2 □ No NIA Baltimore Funeral Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number Winston Avenue 21212 NSA 321 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Mass Transit College (1-4or 5+) lementary/Secondary (0-12) Administration 12th grade Foreman NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elsie Knight Walter Henderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 321 Winston Avenue Baltimore MD 21212 Yvonne Knight Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 07.07.06 Dwings MILLS MD garnson Forest 4 □ Donation 5 □ Other (Specify) Vaughn C. Greene Funeral Sentices 4907 York Road Baltimore MD 21212 21. Signature of Funeral Service Licensee In MO1363 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 2 MO METASTATIC SOUAMOUS CELL CARCINOMA OF THE LUNG Pnysician /Medical Due to (or as a consequence of): 5 DMS Examiner THEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner sicien and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transment. Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2√No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 72. W/, D.O. JUNE 30, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAT HOSPITAZ OF BALTIMORIE JEREMY M. HUFF, P.O. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Miller St. Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 tem 20b per fh 885 / 7-5-06 vt.
State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jacquelyn 3.30 AM Key SUNE 24 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. SINAI HOSOITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 02 9. Birthplace (State or Foreign **Funeral** Days 1□M 252F Months Hours 71 Director 35 19 ΜŐ 219-32-4340 Usual Residence of Decedent 10a. State Mode 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryla Deperment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic avent, if a Medical Exact in an Indial Exact and ODEs. Y Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4222 Fernhill Ave 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2☐ Married JACGUELYN KEY nore, Maryland 21215-0036 δ Yes Give 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced Black Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ementary/Secondary (0-12) College (1-4or 5+) 12th grade na Nurse Private Duty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James R. McCoy Sr. Edna Kellum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Wilson-Sister 4007 Belle Ave, Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial ② ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro_Crematory 7/3/2006 Baltimore, Md 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyings such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physicien end sthe burial-transit deeth certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) ed by the a P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, icate has been sign, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 风Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 X No 24a. Was an director, page 2 autopsy performed? of Vital 1 Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 Aftar this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attanding 1 Natural 5 Pending within 24 hours after deeth.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation M 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 1 Certifying Physician: To the heat of my knowledge, death corumed at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one)

State Registrar

AMANDEEP JIN 111
31. Date filed (Month, Day, Year)

3Q. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

HOSPITAL OF INAI 32. Registrar's Signature

29c. License number

D0063322

BALTIMOTLE

29d. Date signed (Month, Day, Year)

June, 24,2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#19a, per/ID, 857,7/5/06 TT State of Maryland / Department of Health and Mental Hygiene?

20907 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer **Physician** ZINOVY JULY 2006 KARGMAN 2:21 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner OWINGS MILLS
Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
11/04/1946 8009 TOWNSHIP DRIVE UNIT # C BALTIMORE If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 214-92-6045 59 Director ÚKRAINE Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "neturel", or items 23s or 28e-f show other traumatic event, the Middigal Examinar must be notified at BALTIMORE 1 ☐ Yes 2 🕅 No OWINGS MILLS Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8009 TOWNSHIP DRIVE UNIT #C 21117 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "neture!", or Iteme 23: Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Tes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: Š Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) PROPRIETOR CONTRACTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 MEYLACH KARGMAN ROSA 19 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TAMRA KARGMAN / WIFE 8009 TOWNSHIP DRIVE UNIT #C-OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of H
Important: If ite
any injury or of 1 Burial 2 Cremation 3 Removal from State 4 Dopation 5 Other (Specify) Other (Specify) *CHIZUK AMUNO CONG. 07/02/2006 BALTIMORE, MD ire of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 al eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a, Part1, Enter the disease, or complicat shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) PANCMEATIC MATASTATI L **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed es the burial-transit attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation the Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/1/06 218750 107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rs. huntensille MD John I ETTING ms. 107531-ALLS

State Registrar 31. Date filed (Month, Day, Year)

JUL 05

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) pay2,200 17 R **Physician** KOMAN ADOLPH /Medical 4b. City, Town, or Location of Death Balt Was 4g County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltmore C de 0 301/10 1305 bit a If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 05/20/1930 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 € M 2 □ F Days MD 76 220-24-6210 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State if item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Exact trainment be notified at 1 ☐ Yes 2 1 No BALTIMORE STEVENSON MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21153 8615 KELLER AVENUE Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Bfack, White, etc. WHITE 1 MXYes 2 □ No AIR If Yes, Give Year or Dates: FORCE 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) WHOLESALE **PROPRIETOR** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be nd Mental **ZEMEL** KOMAN **JENNIE JACOB** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8615 KELLER AVENUE - STEVENSON, MD 21153 Health itam 27 i CLAIRE KOMAN / WIFE 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Depertment of H Important: If Its any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/03/2006 WOODLAWN, MD SHAARI TFILOH CONG 22. Name and Address of Facility SOL LEVINSON & ERUS., INC. 21. Sign Way 1 Ineral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) 85918a **Physician** /Medical Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of): Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 ☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No S 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 1 | Inpatient 2 ER/Outpatient 3 DOA his After thi 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1 ⊟Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 1 Contitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 32 Aegistrar's Signature 31. Date filed (Month, Day, Year)

Registrar

0 5 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Η. 09 45 AM **Physician** t m ma LongJune 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Assisted Living olumbia sunnise If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 F Yrs. Sept. 29, 1905 100 Director 577-60-6506 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Maryland Howard Direct Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8500 Freetown Road USA Completed by Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Importent: If term 27 is marked other thermany injury or other traumming. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Marned White 1 ☐ Yes 2 ☒ No Specify Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Contract Administrator Navy Dept 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bradley H. Allen Alice Linz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12502 Hall Sharp Road Fulton Robert Hughes/Friend Maryland 20759 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 6/30/2006 4 □ Donation 5 □ Other (Specify) Catonsville, Maryland 21. Signature of Fundral / ervice Licensee 22. Name and Address of Facility With Fleck Funeral Home 7601 Sandy Spring Road Laurel MD 20707 Approximate
Interval Between
Onset and Death
22 Years 23a. Part1. Enforthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) Vascular accident (CVA) Cere bral Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit and/ Due to (or as a consequence of): P.O. Box 68760. the attending physicien Completed by Physician/Medical NIA tF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy Year ō in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Alzheimer's dementia 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? has 1 Yes 2**X** No Division of Vital Hospital or Attending Physicien: 24 hours after death.

Funeral Director: After this certifical etally filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Medical Certification: To 2 ER/Outpatient 3□ DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho To the Func (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number m.D. 56531 cl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mD21044 10780 Hickory Ridge Rd, Columbia, Harry 31. Date filed (Month, Day, Year) State 2006 JUL 0 5 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? 🕦 🕦 🕤 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 8:33 AM M Raymond Thomas Lorek June 30, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth Month, 28, 9. Birthplace (State or Foreign **Funeral** Days Hours 82 Mary Tand 215-14-4107 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: if Itam 27 is marked other then "natural", or Itams 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or itams 23s or 28s-f show the Medical Examiner must be notified at N/A Baltimore Mary land 1 Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3900 E. Northern Parkway 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No WWII If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Pantry Pride 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Anna Raymond Lorek Janowska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: if itam 27 is eny injury or other trau 2009. Randy Lorek/Son 3223 Texas Avenue Parkville Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 7/3/06 Baltimone Maryland 21. Signature of Funeral Service LicenseeChristina L. Hilton 22. Name and Address of Facility Leonard Ruck Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit so the Hospitel or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Wes. 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Director: After Division 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signardie and title of certifier death (Item 23a) (Type, Print) 31. Date filed M Rigistrar's Signature State 05 2006 Registrar

OK DETVI

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 **Physician** 2 16:30 Dorothy H. Lentini July /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1□M 2⊠F August 11, 1923 82 Pennsylvania 578-98-8823 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County i Hygiene. other than "natural", or Iteme 23a or 28a-f ehow rent, Ira Medical Examinar must be notified at Bethesda 1 ☐ Yes 2 🔯 No Montgomery Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20817 United States 6501 Goldsboro Road deeth 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 Tyes 2K No Specify: Specify: White þ 3 K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ith and Mental F 27 is marked of traumatic ever Sarah Cloud Pages 1 and 2 should be Joseph Hoffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6501 Goldsboro Road, Bethesda, Maryland 20817 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 : Department of Health ar Important: If Item 27 ie eny injury or other trau Pasquale S. Lentini Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 7, 1 Burial 2 □ Cremation 3 □ Removal from State Brentwood, Maryland Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda Chevy-Chase 17c 3. 7557 Wisconsin Avenue 21. Signature of Funeral Service Licenses Bethesda Chevy-Chase Inc Bethesda, Maryland 20814-M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 physician Physician/Medical the the attending 950 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No
9 Unknown ò 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate hes been sig r, page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wasan autopsy perform 217 1 ☐ Yes 2 ☐ No this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No 3□ DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 1 Naturai 5 Pending To the more after death, within 24 hours after death.

To the Funeral Director: Att r death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗆 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 7/3/26029b. Signature and title of certifier 00062435 who completed cause of death (Item 23a) (Type, Print) Medialate Dr. Rockille, MD 20850 SAYED M. ELSAYYAO 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician JŬĽŸ 2006 6:46 P M HANNAH LUBIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 4730 ATRIUM COURT #277 OWINGS MILLS 8. Date of Birth 11/25/1908 If Under 1 Year | II Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2 F 97 Yrs. 217-22-6916 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ir then "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2¥ No OWINGS MILLS Directo BALTIMORE MD 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 4730 ATRIUM COURT #277 21117 U.S.A. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. WHITE filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry completed. Elementary/Secondary (0-12) College (1-4or 5+) OFFICE MANAGER MEDICAL 12 .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: if item 27 is marked other t jury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MACKS **ROSE** LEVINSON **JOSEPH** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 CROSS KEYS ROAD #66 - BALTIMORE, MD 21210 ELLIS FRIBUSH / SON-IN-LAW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal Irom State Department of Important: if eny injury or once. HEBREW FRIENDSHIP 07/04/2006 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signatura Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. Listority one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINOMA OF **Physician** MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificete has but the sector, page 2 s autopsy performed 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: Cther: Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes ► No ို 1 Inpatient 2 ER/Outpatient 3□ DOA After the 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending м 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Do019317 9 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 GARENETREE RD STE 300 BALTEMORE, MD 21208 KERZNER 31. Date filed (Month, Day, Year) 3 Registrar's Signature State 0 5 2006 Registrar

Please Type or Print in Black Indelible Ink

Jerome Saul Levin	1- For State Registrar	51	ate of Maryland		iment of I ficate of L			eg No. 2 Ω	NE 2001
Physician/ Medical Examine	1. Decedent	s Name (First, Midd	,	 AUL		LEVINE	2 Date of Dea Month June 28, 2	th Day Year	3 Time of Death 1246 hrs
	4a Facility N		on, give street and number)			City, Town, or Location Owings Mills		4c. County of De Baltimore C	
Funeral		0/42 Number	6. Sex 7. Ag	e (In yrs last		If Under 1 Year If Und		th(MM/DD/YYYY) 9	Birthplace (State or
Director	213-3	2-4349	1 X M 2 F	40	Yrs	Months Days Hou	ns Min 05/20/		eign Country) MD
w any	10a. State	10b. County			own or Location				10d Inside City Limits
the Maryland a or 28a-f shor tified at once. Director	MD 10e. Street a		ΓΙΜΟRE	OWI	NGS MIL	LS 0f. Zip Code	11	0g. Citizen of What C	1 Yes 2 X No
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21215-0036 total be filed within 7 total d Mental Hygiene. is marked offer than tic event, the Medica To Be Comple	MARK	nt's Name/Relations	ship (Type, Print.)	Ī	LEVINE		ILDRED umber or Rural Route Num	pher City or Town St	BING
MD 2 shot all the and I is a sumatic	MARK	LEVINE /			20 NO	RRIS RUN CO	OURT - REIST	ERSTOWN, N	MD 21136
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 X Buria		n 3 Removal from Sta	ate cre	matory or other		Date 07/02/2006	20c. Location - City	, and the second
Saltin ermit P Departme mportar ujury or		tion 5 Other S		P1711X		ne and Address of Facil	IA.	NSON & BRO	
Physician	23a. Part I. E	Inter the disease, or List only one cause	complications that caused	the death. D	o not enter the	00 REISTERS mode of dying, such as	STOWN ROAD - cardiac or respiratory arre	PIKESVILI est, shock, or heart	E MD 21208 Approxima e n erval
/Medical Examiner	Immediate C	ause (Final disease resulting in death)	Sorrano Dia						Between Onset and Death
	Sequentially	list conditions,	b						
ted Insit	cause. Ente	ng to immediate or Underlying Cause	Due to (or as a consecutive to (or a))).					111	
and - transit		ting in death) Last	d		7	057 7/10/00 T	, , , , , , , , , , , , , , , , , , , 		
'60, cate be execu physician and he burial - tra	TUNPE		23c. If yes, outcor	n#5, perf	7, por ME H, C857, 7	357,7/12/06 T /17/06 II		23d Date of deliv	erv
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transis hysician/Medical Ex	23b Was dec past 12 i		L LIVE DITUT	time of death		death 3 Ectop	pic pregnancy	Month	Day Year
a e a a a a a a a	Part II. Othe		known 9 Unknown	n but not resu			Part I 23e Did to	bacco use contribute	to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rastic death "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P	7								robably 4 Vunknown
Records, The law requires freate has been sig							24a Wasa autop		autopsy findings available o completion of cause of
al Reconstitute tor, page		e referred to medica	ıl			26.Place of Deatl	1 Yes		
n of Vital Records, ding Physician: The law requir After this certificate has been s foneral director, page 2 should on: To Be Completee	1 V Ye	s 2 No	Hospital: 1 Inpatie		R/Outpatient 3			Residence 6 Ott	ner Scene
ion o tending eath tor: Aft the fune	1 X Natu	ral 5 Pen	(Month, Day,Y	ear)	ob Time of Inju	1 Yes 2	_	low injury occurred	
Division or spiral or attending tours after death meral Director: After filled in by the fune Certification:	3 Suic	ide 6 Cou		jury - At hom	e, farm, street,	factory, office building,	etc. 28f, Location (S or Town, S		Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the ledical Certification	79a. Cerunei	Centifying P	hysician: To the best of m						
To the He within 24 To the Fu completel	29b. Signatu	2 Medical Exa	miner: On the basis of exa and manner stated er	mination and	or investigation	29c. License numbe		and place, and due to	
		and	eHac	lau	_	O.C.M.E.		June 29, 2006	
			who completed cause of d sistant Medical Exar		,	eet, Baltimore, Mi	D 21201		
State Registra		(Month, Day, Year)		r's Signature	Secret "				
DHMH 17 Rev 1/2001		<u>v. v v (0</u> 1	A A A A A A A A A A A A A A A A A A A	1	ORIGINAL				

Martin Joshua Mireles

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygic

		1- For State Registrar	Ce	ertificate of Death	and Mental Hygiene	Reg. No 20	06 200
Physic Medical Exan	ian ine	• Martin	Joshua	Mireles	2. Date of Month	f Death	3 Time of Death 0826 hrs
And the second		4a Facility Name (if not instituti 618 New Jersey Aver	on, give street and number)	4b City, Tow	n, or Location of Death	4c. County of De	ath
Funera		5. Social Security Number	6. Sex 7. Age (In yrs	Glen Bu		Anne Arund	
Directo		220-02-2304	1 X M 2 F 26	Yrs Months		47 4000 Enr	eign Country) Maryland
, any		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Location			10d Inside City Limits
daryland 28a-f show any 1 at once,	١	Md. Anne	e Arundel	Glen Buri	nie		1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	618 New Jerse	AVA	10f. Zip Coo	-	10g Citizen of What Co	untry?
15-0036 filed within 72 hours after death with the Maryland Hygiene d other than "natural", or items 23a or 28a-f she is the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 M	12. Was Decedent Ever in U	J.S. 13. Was Decedent of	1060 f Hispanic Origin? (Specify Yes c	USA or No- 14. Race - Ame	erican Indian, 8lack,
ifter dea I'', or it	Full	3 Widowed 4 Div	vorced If Yes, Give Year or Dates	1 Yes 2 X	uban, Mexican, Puerto Rican, etc.) White, etc	
hours a	ted by		ecify only highest grade completed)	16a Decedent's Usual Occi	upation (Give kind of work done life DO NOT use retired)	Specify: 16b. Kind of Business	White s/Industry
5-0036 led within 72 lygiene other than "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	1	tion/ Flooring	Fi	inishing
21215-0036 und be filed within 7 Mental Hygiene marked other than c event, the Medica					18.Mother's Name (First, Midd	Installati	on
2121! hould be fill nd Mental I is marked tite event, i	To Be	Martin 19a Informant's Name/Relations	Lee Mirele		Barbara treet and Number or Rural Route	Pump	phrey
ore, MD es 1 and 2 sho of Health and If item 27 is		Martin L. Mire		618 New Jer	sev Ave. Glen F	Burnie, Md. 2	21060
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked nijury or other traumatic event,		1 X Burial 2 Cremation	Removal from State	crematory or other place)	cemetery, Date	20c. Location - City o	r Town, State
Baltimo permit. Page Department o Important: I		4 Donation 5 Other Street 21. Signature of Funeral Service	pecify: United the second of t	en Haven Cem. 22 Name and Addr	7/7/06 Tess of Facility Staling	Glen Burni	e, Md.
? Physician		23 Part Ente the diseas for	millications that caused the death or each line.	1.5 1 1 1 190110	ITAIN DA Deceda	ana Malagara	2
/Medical Examiner		Immediate Cause (Final disease		lcohol intoxication		arrest, shock, or heart	Approximate Interval Between Onset and Death
		or condition resulting in death)	Due to (or as a consequence of	f):	<u> </u>		Deali
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	f):			+
ed nsit	Examine	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of	f):			
e evecuted sian and ial - transit		XUNPENDED	d AMENDED :	07.00 6 17.0			
8760, idficate be ex ng physician as the burial.	n/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr	a,27,28a-f,perMEg8	358,8/25/06 TT	23d. Date of delivery	<u></u>
Box 687 e death certifine the attending of for use as t	sicial	past 12 months?	4 Pregnant at time of dea	2 Fetal death 3 ath 5 Other (Specify)	Ectopic pregnancy		Day Year
Ш % € ₽	Phy		ons contributing to death but not re	sulting in the underlying cause	a given in Port I		
S, P.O. uires that the n signed by id be detach	ed by					d tobacco use contribute to Yes 2 No 3 Prob	
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	Completed				24a Wa	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	topsy findings available ompletion of cause of
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n of Vital ing Physician: After this certif uneral director,	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 I	ER/Outpatient 3 DOA	oce of Death (Check only one) Other Nursing Home 5	Residence 6 🗸 Other	Scane
on of anding Phath		27. Manner of Death 1 Natural 5 Pendir	(Mortili, Day, Year)			e how injury occurred	Counc
Division pital or Attendio ours after death erral Director: A	Certification;		igation FIR 6/30/2006	Fnd 6:15 am	Yes 2 X unk building, etc. 28f Location	(Street and Number or Rur	ral Pouto Number City
lospital 4 hours 10 meral		4 Homicide determ	nined (Specify) found a	at home	PIGI DUI		
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi completely filled in by the funeral director.	Medical	(Check only one) 2 Medical Exam	vsician: To the best of my knowledge iner:On the basis of examination and and manner stated	e, death occurred at the time, of d/or investigation, in my opinio	date and place, and due to the cal on, death occurred at the time, dat	use(s) and manner as starte te and place, and due to the	e cause(s)
F > F 0	žΪ	29b. Signature and title of certifier	A //	29c. Licen	ise number	29d Date signed (Mon	
	+	30. Name and address of person w	/ho complete cause of death (Item 2		.M.E.	July 1, 2006	
		Jack Titus MD. Depu	ty Chief Medical Examiner	111 Penn Street, Ba	Itimore, MD 21201		
Sta Registi	ite rar	31. Date filed (Month, Day, Year)	2. Registrar's Signature	Specie			
DHMH 17 Rev 1/20				-			

Amend item#23a,perMF,9857,7/5/06 TT State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0091 0 /Medical Center 4b. City Toyn, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Kehab If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 10 M 2□F Director mar auna Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 100 Maggie Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ISA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Newer Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 Specify: Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pagas 1 and 2 should be filed wit Dapartment of Haaith and Mantal Hygiant important; if flem 27 is marked other the any liqury or other treumatic event, the ODGs. alesmai 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be ပ Se 19a. Informant's Name/Fela onship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21040 decloor InD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other; c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 Removal from State 4 ☐ Donation 3 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Faulity vans FORSTHILL 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Renal Disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s tha burial-transit Hospital or Attending Physician: The law requires that the death cartificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 1□ Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one, examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Cther. 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 ☐ Yes 2 No 3□ DOA this Aftar this 28b. Time of Injury 28c. Injury at Work? Certification; 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No I Director: A investigation 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fillad in by within 24 hours after To the Funeral Direct 4 Homicide t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 032279 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHY. Boldin ma DAV.D 5 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Marie B. 1:05[™] M Matacotta July 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2916 Alvarado Square Baltimore If Under 1 Year II Under 24 Hrs.
Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 1 F 219-18-9100 Yrs Director June 7,1923 New York Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits and Mental Hygiene. Is marked other then "naturet", or items 23s or 28s-f show raumatic event, the Medical Exemples must be notified at TY Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2916 Alvarado Square 21234 U. S. A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: Specify: White 3€Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government Personnel Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ould be Norman C. Bloodsworth Alica Aaron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2::
Department of Health ar
Importent: If Item 27 te
any injury or other trau Peter V. Gargano/ Lawyer 6941 Holabird Ave. Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 7/6/06 * 4 ☐Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chanel, P.A. 6009 Harford Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** all myocafdia 1Pars disease or condition resulting in death) /Medical Due lo (or as a consequence ol): Examiner hupleter is a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated according Examiner ospitel or Attending Physician: The law requires that the death certificate be executed hours after death. use as the burial-transit signed by the attending physicien and d be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peed 24a, Was an 24b. Were autopsy lindings available prior to completion of cause of death?

1 Yes 2 No this certificate has autopsy performed? res 200,No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 6 Residence 6 Other (Specify) 1 ☐ Yes ≥ No Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident 5 Pending after death.

Director: Af
in by the fur 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15000 9 K mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lod Erdner Avenue 3120 10 32 Registrar's Signature 31. Date liled (Month, 2006 State

Registrar

			1 - For State Registrar	State of Mary		artment of ertificate o			jiene _{eg. No.} 2006	20917
	Physici /Medic		Decedent's Name (First, Middle, Last	Dorothy	McAllis	ster		2. Date of Dea Month	Day Year 22 ZOO	3. Time of Death 6 437 AM
	Examir	-	4a. Facility Name (If not institution, gived Union Memorial 5. Social Security Number 6. S	Hospital 1	took brindbada	Ba	or Location of Dec 1timore ar If Under 24 Hi		4c. County of Dea	
	Funeral Director			ex 7. Age (IIII	yrs. last birthday 71 Yrs.	Months Day		n. (Month, Day	78,1935 Mar	thplace (State or Foreign ountry) Ylanc
	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow ha Medical Examinar must be notilled at	Director	10a. State 10b. County Maryland 10e. Street and Number	100	c. City, Town or L	Balt	imore			10d. Inside City Limits N☐ Yes 2 ☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Dir		12. Was Decedent Ever		10f. Zip Code Was Decedent of	21201	(Specify Yes or No-	U. S. A.	erican Indian,
-0036	hours after tural', or ite	ed by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 □ Yes 2 💆 N	lo <i>Specify</i> :	nican, etc.)	Specify:Bla	ck
Maryland 21215-0036	od within 72 giene. er than "nate, the Medici	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Giv	edent's Usual Occ e kind of work do DO NOT use ret Custodi	ne during most of w ired)	rorking	City Sc	
yland	should be file and Mental Hy s marked oth umatic event	To Be (17. Father's Name (First, Middle, Last)	James Mac					Maiden Surname) U	
	Health and tem 27 is nother traum		19a. Informant's Name/Relationship (1) Timothy J. Norwo 20a. Method of Disposition	od \ Son	2852 0b. Place of Disp	Harford	Road Ba	ltimore,M	r, <i>City or Town, State,</i> [aryland 21 20c. Location - City or	218
Baltimore,	mit. Pages bartment of sortent: if i r injury or c		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	<i>'</i>)	Mt. Carm	ematory or other pel Cemet 22. Name and Add	ery 7/1	/2.006 E	Baltimore,	Maryland
Ä	permi Depa Impo any ii		23a. Part 1. Enter the disease, or compshock, or heart failure. List only	plications that caused the		009 Har	Ford Road	<u>Baltimo</u>	uneral Cha re,Marylan	Del, P.A. d 21214 Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. LUNG Due to (or as a so	nsequence of):	cer	1-00			Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as 🚓 to	nsequence of):	euval non re		venese)	hours
8760,	icete be executed physiclen and s the burial-transit		resulting in death) Last	Oue to (or as a cond.	nsequence of);					
.O. Box 6	Physician: The law requires that the death certific this certificete has been signed by the attending p rat director, page 2 should be detached for use as:	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregna □ Other (specify)			23d. Date of de Month	livery Day Year
ords, P.	w requires that been signed is should be det	þ	Part II. Other significant conditions o	ontributing to death but no	ot resulting in the	underlying cause	given in Part I.		bacco use contribute to es 2 □ No 3 □ P	10
Vital Record	itcien: The law i certificete hes bu rector, page 2 sh	e Completed	25. Was case referred to medical					24a. Was a autops perfor 1 ☐ Yes	y prior to	utopsy findings available completion of cause of
ō	Attending Physician: r death. ector: After this certifice by the funeral director, I	ToB	examiner? 1 Yes 2 Do 27 Manner of Death 1 Accident Investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time o Injury	of 28c. In	Other: 4 Nursing		ence 6 □Other (Spe ow injury occurred	cify)
Division	Hospital or Atten 24 hours after deal Funeral Director: 1ely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, sipecify)	treet, factory, offic	Ç10	28f. Location (St City or Town	reet and Number or Ri n, State)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Sertifying Ph 2 Medical Examone)	ysician: To the best of my niner: On the basis of exa and manner stated.	mination and/or i	nvestigation, in m	time, date and placy opinion, death occurrence number	curred at the time, d	ate and place, and due	o to the cause(s)
	7.37.8	_	30. Name and address of person who	completed cause of death	MIKE (Item \$3a) (Type	/	T24389	46	9d. Date signed (Mont June 27	
4	Sta	te	MARITA MILE 31. Date filed (Month, Day, Year)	JE MD	Union	Mem	vial H	ocpital		
	Regist	ar	JUL 0 5 200	De san .	11 1600					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Rag. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 4a. Facility Name (If not institution, give street and number) 5:00 AM 2000 /Medical 4. County of Death 4b. City, Town, or Location of Death Examiner BelAIr chesa ocake r-torc If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Days Hours 52 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fehov nit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla hardment of Health and Mental Hyglene. cortant: If team 27 is marked other then "nature!", or iteme 23a or 28a-1 ehow injury or other transmatic event, its wastes Exacting trained to incline a minimum or other transmatic event. 1 Yes 2 No Director rretts 10g. Citizen of What Country? 10e. Street and Number 1118 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Yes 2 No 1 ☐ Never Married 2 ☑ Married 1 🗆 Yes 2 No Specify: White If Yes, Give Year or Dates: Army 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be liller ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If Item 27 is chrome Hillrd 20c. Location - City or Town, State Baltimore. Date 20a, Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 Removal from State Baltimore Ch 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility EVOINS 21. Signature of Funeral Service, License Funeral Chapet-Beltir NewPort MD 21050 Forest Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, of shock, or heart failure. List Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Figal disease or condition resulting in death) Infarction minutes **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner use as the burial-transit Due to (or as a consequence of) 68760, ettending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 4 Pregnant at time of death isigned by the elid be detached for P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by DIJEASE 3 Probably 4 DUNKNOWN 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an director, page 2 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ု 1 Yes 2 1 No 2 PCR/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Division 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation the 2 Accident within 24 hours after deatl To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital 1 Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. .29a. Certifier 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
JUL 0 5 2006

Kevin

CYNIGHTOND 2

32. Registrar's Signature

06

no completed cause of death (Item 23a) (Type, Print)

· OBIG

ORIGINAL

D350/2

North Ave.

		1 - For State Registrar	State of I	Marylan		artmer <i>rtificat</i>				_	giene Reg. No.	2000	5 2091
C v		1. Decedent's Name (First, Middle, La			(2. Date of De. Month	ath , Day	Year	3. Time of Death
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Examin	er	4a. Facility Name (If not institution, give	re street and numb	er) Exitte	nose	4b. City.	Town, or	Location	of Death		4c. C	ounty of Deat	h
	-	5. Social Security Number 6.5	rolled Ci	Age (In yrs. I	new last hirthday	If Unde	1 Year	If Under	24 Hrs.	8. Date of Birt	th	NA	nplace (State or Foreign
Funeral Director		,	1 ☐ M 2 🔀 F	84	Yrs.	Months	Days	Hours	Min.	(Month, Da 5-30-1	y, Year)	Co	MARYLAND
		Usual Residence of Decedent				1	11						
arylar ahow	_	10a. State 10b. County	-	10c. City	y, Town or L	ocation							10d. Inside City Limits
ith the Marylar or 28a-f ehow	Director		TIMORE			106.70	0.1		ROSE	DALE	10 000		1 ☐ Yes 2X No
with t	ក់	10e. Street and Number 204 PATAPSCO AV	יביאוו זבי			101. 21	Code	227			10g. Citize	on of What Co	
Jeath ms 23	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13.	Was Dece		237 spanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)	- 14	U.S.	
or Ites		1 Never Married 2 Married	Armed Force 1 XYes 2 If Yes, Give	□No		If Yes, spe				Rican, etc.)		Black, White	e, etc.
ireli,	d by	3 Widowed 4 □ Divorced	Year or Date	s1944-4	45	T Tes	21 2 N0	Specify:			S	pecify: V	HITE
ified within 72 hours after death with the Maryland Hygiene. Wher then "naturel", or Items 23s or 28s-f show only, the Modical Exemities in the natified at	Completed	15. Decedent's E (Specify only highest gr			(Give	dent's Usu kind of wo DO NOT u	ork done a	<i>lurina</i> mos	t of worki	ng	16b. Kind	f of Business/	Industry
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Hygined Physical Phys	0	17. Father's Name (First, Middle, Last	")						er's Name	(First, Middle,	Maiden S		
Id be Mental rked o	To B	RAYMOND		WARTI	HEN ~			LII	LIAN			(REXRO	лн)
ie, well yidlic ZIZIOOOO	-	19a. Informant's Name/Relationship	Type, Print)		19b. Maili	ng Addres	s (Street a	and Numbe	er or Rura	I Route Numbe	er, City or	Town, State, Z	ip Code)
and and and and and and and and and and		ERIC WARTHEN/ NE	PHEW		_	EDGE		R AVE			DALE,	, MD	21237
3 0 0		20a. Method of Disposition 1 St Buriat 2 ☐ Cremation 3 ☐	Removal from Sta		face of Dispo emetery, cre	osition (Na matory or	me of other place	θ)	С	ate	20c. Loca	ation - City or	Town, State
nit. Page: artment o ortant: if injury or		4 ☐ Donation 5 ☐ Other (Speci	fy)		RRISON			1		-2006			LLS, MD
permit. Pag Department Important: I any injury o		21. Signatore of Funeral Service Lice	nsee ()	***	1			s of Facili		CH/ROSE			
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cate be executed physician and the burial-transit	dical Examin	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or	as a consequ	uence of):								
The Collas, T.O. BOX of The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown		h 2 ☐ Fetal It at time of d	Ideath 3	⊒Ectopic p ⊒ Other (s)					23	d. Date of deti Month	very Day Year
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The I	Completed									autor perfo	ormed? 2 X No	prior to death? 1 ☐ Yes	comptetion of cause of 2 \(\subseteq \text{No} \)
stan:	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20110
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or Attend free death lirector: ,	ertification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of	Injury - At ho	ome, farm, st	M reet, factor		Yes 2 🗌		28f. Location (S City or Tox		Number or Ru	ral Route Number,
To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Ce	29a. Certifier 1 ★ Certifying P (Check only 0 me) (Check only 1 ★ Certifying P	hysician: To the be miner: On the basi and manner	is of examina	wledge, dea tion and/or in	th occurred	at the tim	ne, date an	nd place, a	and due to the ed at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
o the o the omple	Med	29b. Signature and the of certifier					c. License				29d. Date	gigned (Monti	n, Day, Year)
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-		30. Name and address of person who	completed cause	of death (Item	n 23a) (Type	Print) 🔽	IAN	16, Rt	NES	57	140	2/10	
Q		3900 Lock A	Paven	Blue	d	Brl	time		,	MO	3/2	18	
Sta Regist		31. Date filed (Month, Day, Year)	32 Reg	istrar's Signa		whi							

			For State	State of Marylan	d / Departm	ent of Health and	Mental Hyg	iene 2006 2	0921
			Registrar 1, Decedent's Name (First, Middle, Last)		Certific	ate of Death	2. Date of Dea		ne of Death
	Physici /Medio		Harold Mc I	HTYRE			Month	30 2006 A	- 40m
	Examir		4a. Facility Name (If not institution, give	street and number)	11 Ct 20	ity, Town, or Location of De	ath	4c. County of Death	4.4
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		der 1 Year II Under 24 H		Year) 9. Birthplace (Sta	Te or Foreign
	Director		211-16-0739	M 2□F 78	Yrs. Mont	hs Days Hours Mi	n. (Month, Day	927 PA	
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location			10d. Insid	le City Limits
	e Man	ctor	MD	B	altimo	re		1 🕱	Yes 2□No
	death with the Maryland ims 23a or 28a-f ehow ir must be notified at	Funeral Director	10e. Street and Number	LAVE APT.	10f.	Zip Code	1	0g. Citizen of What Country?	
	ns 23	erai		12. Was Decedent Ever in U		21206 ecedent of Hispanic Origin?	(Specify Yes or No-	USA 14. Race - American India	η,
ထ္က	or ite	/ Fur	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give		ecedent of Hispanic Origin? specify Cuban, Mexican, Pu- s 2 No Specify:	erto Rican, etc.)	Black, White, etc.	
Ö	within 72 hours after ene. then "natural", or ite he MacJeal Examina	ed by	3 ₩idowed 4 Divorced 15. Decedent's Edu	Year or Dates: VV W	16a. Decedent's U			Black 16b. Kind of Business/Industry	
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Maryland 21215-0036	e d sa b	To Be	17. Father's Name (First, Middle, Last) Clarence Mc	INTURF		ANN	ame (First, Middle, I	Maiden Surname) TU	
ary	2 should and Men ie marke eumatic	Ĕ	19a. Informant's Name/Relationship (Ty	pe, Print) /STeP-		ress (Street and Number or	Rural Route Number	, City or Town, State, Zip Code)	
	and 2 leelth a m 27 is		Patricia Arrivi	TON/DavghTe	3866 4	YNDAIEAV	e. Balti	More, MD, 2/2 20c. Location - City or Town, State	-13
Baltimore,	Pages 1 nent of H int: if ite iry or ot		1 Surial 2 Cremation 3 □R	amount from State	emetery, crematory	or otner place)			
Ħ	permit. Pag Depertment Importent: any injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		Crison F	and Address of Facility B	10/2006 C arrall I. H	wings mills, M unier FNRL. Ser	10.
<u>~</u>	Depe impo any i		Danella, Hu	nter	2007	09 EasTern	Ave. Balli	More MD. 2123	1
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat ne cause on each line.	h. Do not enter the r	node of dying, such as cardi	ac or respiratory arr	Interval	mate Between and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Status	Eples	Hows		CACOLAC	
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8760,	The law requires that the death certificate be executed tie hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	cal		·	, 				
9	artifical ing phy e as th	77	IF FEMALE:						
Вох	death certifica attending pt d for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1☐Live birth 2☐Fetal 4☐Pregnant at time of d	I death 3 ☐ Ectopi	pregnancy		23d. Date of delivery Month Day	Year
o.	that the death cen ed by the attendin detached for use	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9⊟ Unknown	eath 5 ☐ Other	(ѕреспу)			
S, D	res thai	by P	Part II. Dther significant conditions con	tributing to death but not rest	ulting in the underlyin	g cause given in Part I.	23e. Did tob	acco use contribute to the cause	of death?
ord	w requir been si should	eted					1 □ Y€	s 2 No 3 Probably	∬Unknown
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ita		Be Co	25. Was case referred to medical			26. Place of De	1 ☐ Yes 2 eath Check only on	SONo 1 ☐ Yes 2 ☐ No	
Division of Vital Records,	Attending Physician: r deeth. sctor: After this certifici by the funeral director, i	은	1 195 2 199	-		DOA Other: 4 Nursing	-10,71	nce 6 Other (Specify)	
o	ding P. h. After funera	tlon:	27. Manner of De ith 1	28a. Dale of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
N S	al or Attending Phy efter deeth. I Director: After this d in by the funeral d	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho	ome, farm, street, fac		28f Location (St	eet and Number or Rural Route N	lumber,
ā	To the Hospital or Attenwithin 24 hours efter deet To the Funeral Director: completely filled in by the			building, etc. (Specify			City or Town		
	Mospital 24 hours Funeral etely filled	edicai	29a. Certifier Certifying Phys	ician: To the best of my kno- ler: On the basis of examinal and manner stated.	wledge, death occuri tion and/or investigat	ed at the time, date and plaction, in my opinion, death occ	ce, and due to the ca curred at the time, da	use(s) and manner as stated. ite and place, and due to the caus	ie(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and mariner states.		29c. License number	25	d. Date signed (Month, Dey, Yea	r)
			· Cm	HMS	>	RGS-UOT	5	Tre/30/200	6.
	7		30. Name and address of person who co		23a) (Type, Print)	ela . A -	0 11	7	071
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signal	1940 64	stem Ave	Baltin	nove, my	
	Registr		.1111 0 5 2006	29	Brook)			

Please Type or Print in Black Indelible Ink Thomas Joseph Muffoletto State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Medical Examine Thomas J. Muffoletto June 29, 2006 0945 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9022 Town and Country Boulevard, Apt Ellicott City Howard 5. Social Security Number If Under 24Hrs **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year 8 Date of Birth(MM/DD/YYYY) 9 Birthplace (State or Days Months Min Hours Director 216-72-9472 1 X M 2 49 Dec. 26, 1956 Usual Residence of Decedent IOc. City, Town or Location 10d. Inside City Limits MD show Howard Ellicott City 1 Yes 2 X No or items 23a or 28a-f sho Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygone anti- (I filem 27 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once. Director 10e Street and Number 10g Citizen of What Country 9022B Town & Country Boulevard 21043 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 14 Race - American Indian, Black 1 Never Married White etc Yes 3 X Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Landscaper Landscaping 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Salvatore J. Muffoletto Be Floraine Sabov 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 19a. Informant's Name/Relationship (Type, Print) Mr. Mark J. Muffoletto (Brother) 3201 Rogers Avenue, Suite 102, Ellicott City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State All County Cremation 7/3/2006 Sykesville, MD **Jepartment** Donation 5 Other Specify 21. Signature of Funeral Service Licenses HATCHT AGUNERAL HOME & CHAPEL, PA (Bosykesville, MD 21784 (410)-795-1400 M00764 Buar 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interva failure. List only one cause on each line Between Onset and Death /Medical Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and tran Physician/Medical AMENDED 23a, pt.11,27 per me g858 8-28-06 vt g physician a X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown **Emphysema** 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed death? ✔ Yes 2 1 V Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient DOA ER/Outpatient 3 Nursing Home 5 Residence 6 V Other Scene 1 🗸 Yes Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b Time of Injury 28d Describe how injury occurred A 24 hours after Geau...

A 24 hours after Geau...

The Funeral Director: A'

CTI ed in by the fire 1 X Natural 5 Pending 1 Yes 2 No Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person 31. Date filed (Month, Day, Year)

State Registrar

29b. Signature and little of certi

who completed cause of death (Item 23a) Assistant Medical Examiner Susan Hogan MD

legistrar's Signature

ORIGINAL

29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d Date signed (Month, Day, Year)

June 30, 2006

5:00

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		1 - For State Registrar	State of I	Maryland		artment of <i>tificate of</i>		and Me		giene Reg. No.	21111	6 2092
Physicia /Medic		DORIS NO	e, Last) RMAN						Date of Dea Month June		2006 ^{Year}	3. Time of Death 8:45 A
Examin	er	4a. Facility Name (If not institution Manor Care 5. Social Security Number	-Ruxton			4b. City, Town, TON	wson				Balti	more
Funeral Director		216-28-0459 Usual Residence of Decedent	1 □ M 2 X (X	Age (In yrs. Ia 74	Yrs.	Months Days		Min.	Date of Birt (Month, Day Sept. 1	8, 19	31 Ba	ithplace (State or Fore, country) LICIMORE
e-f show	ctor	MD 10b. County	arford	10c. City	. Town or Lo Edge	ewood						10d. Inside City Lim 1 ☐ Yes 2 ☐X
23a or 28	Funeral Director	1934 Chippe	r Drive			10f. Zip Code 2	1040			10g. Citiz	zen of What C	
one than "natural", or itams 23a or 28e-f show the Modical Examiner must be notified at	P P	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes, Give	es? X⊠No		Vas Decedent of f Yes, specify Cu I ☐ Yes 2X No	ban, Mexican Specify:	gin? (Specif i, Puerto Ric	y Yes or No- can, etc.)		14. Race - Am Black, Wh Specify:	White
it of Health and Mental Hygiene. If item 27 is marked other than "nature or other traumatic event, the Medical or other traumatic event, the Medical or other traumatic event, the Medical or other traumatic event, the Medical or other traumatic event, the Medical or other traumatic event, the Medical or other traumatic event, the Medical or other traumatic events.	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4c	or 5+)	(Give life. l	kind of work done 00 NOT use retire chboar	e during mast ed)					d Emmeric
and Mental Hygiene. Is markad other than aumatic event, Ire M	To Be (17. Father's Name (First, Middle, George Beve.	ridge				Ros	ie Be	erlin		,	
of Health and item 27 is m other traum		19a. Informant's Name/Relations Paul G. Potl 20a. Method of Disposition		20b. Pla	9023	g Address (Stree Field sition (Name of	chat 1		Nott:	ingh		21236
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is certificate director, pag	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa	atient 2 E	R/Outpatien	3 DOA Ot			Check only on 5 ☐ Reside		Other (Spe	ecify)
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n 24 hours ne Funeral bletely filled			1			00-11	an number		2	9d. Date	signed (Mon	
within 24 hours after death. To the Funeral Director: After completely filled in by the fune	W	29b. Signature and title of certifie	Elcol.	3,		29c. Licen	6812	840	3	6	-29	in, Day, Year) - C 6 Y D 2/2

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** Robert Glen Paige, Sr. 2006 6 25 12:35a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 804 N. Central Avenue Baltimore NA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Min 1(XM 2□ F 213-32-7145 Yrs. Director 8-14-36 Md Usual Residence of Decedent the Maryland 10a State 10c. City. Town or Location 10b County 10d. Inside City Limits 28a-t show or other traumatic avent, the Madical Examinar must be notified at Md. NΔ 1X Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 804 N. Central Avenue or items 23a 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important; if itam 27 is marked other than "natural; or iten any injury or other traumatic avent, the Mudical Expir. art. ODE. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: <u>م</u> Specify: 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Forklift Driver Coca Cola 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paige Thompson Andrew Rosanna ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Bowley Sister 3911 Tiverton Rd, Randallstown, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 6-28-06 Randallstown, Md. King Mem. Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 l ade Wan March F.H. East 1101 E. North Ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Von-small /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 19 use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cete has been si, , page 2 should t 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 ☐ Yes Division of Vital i or Attending Physician: after death. Director: After this certifice completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 \(\sum \) Nursing Home 1 ☐ Yes 2 No 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number D0061040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hoplans Hospital II. 31. Date filed (Month, State 0 Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	H	-For State Amend Item#21 Per FH G857/tiff	4Q5dQ	beatH				g. No.	2000 209
Physician ledical Examine	~	1. Decedent's Name (First, Middle,Last) Edward Perez					Date of Deat Month June 25, 2	Day Yea	3. Time of Death 1120 hrs
		4a. Facility Name (if not institution, give street and number) 1304 Anglesea Street Apartment T-4		. City, Town, or Lo Baltimore City		Death	-	4c. County c	of Death
Funeral		5. Social Security Number 6. Sex 7. Age (in yrs. last bit		If Under 1 Year		24Hrs.	8. Date of Birt	h(MM/DD/YYYY)	9. Birthplace (State or
Director		$219-52-9337$ $_{1}$ $_{X_{M}}$ $_{2}$ $_{F}$ 56	Yrs.	Months Days	Hours	Min.	7-28	Foreign Country) MD	
.	<u> </u>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	Town or Location 10d. Inside						
d d				City					1 Yes 2 No
Varyland 28a-f show any d at once.	Director	10e. Street and Number		10f. Zip Code			10	g. Citizen of Wh	21
ith the Maryland 23a or 28a-f sho notified at once		1304 Anglesea St., Apt. T-4		21224				USA	
ath wit	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?		Decedent of Hispa s, specify Cuban, N				14. Race White	- American Indian, Black, e, etc.
fter de		1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year	1 Y	es 2 No	specify:			Specify:	White
hours a	ed by			Usual Occupation				16b. Kind of Bu	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she taken of the Maryland at once the comit, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Di	sabled				Dis	sabled
5-00 led wit Tygien other	하	17. Father's Name (First, Middle, Last)		18				Maiden Surname))
21215-0036 and be filed within 7 Mental Hygiene. marked other than ic event, the Medica	a	George Perez 19a. Informant's Name/Relationship (Type, Print)	Oh Mailing /	Addross (Street			e Sut		n, State, Zip Code)
nore, MD 21 Bgs I and 2 should nt of Health and Me T. If tien 27 is ma other traumatic ev	٥								MD 21224
re, ME s. 1 and 2 s of Health au If item 27		20a. Method of Disposition 20b. Place	of Dispositi	on (Name of ceme	etery,	Е	Date	20c. Location -	City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite	L	4 Donation 5 Other Specify: Mt.	Carme	el Cem.		7 – 1			more, MD
Baltimo permit. Page Department of Important: injury or oth		21. Signature of Funeral Service Licensee per DVR	22. Na	me and Address o	of Facility B	rad	ley-A	shton l	Funeral Home,
Physician	+	Beth A. Kehl M01455 23a. Part I. Enter the disease, or complications that caused the death. Do r	ot enter the	2134 I mode of dying, su	Will uch as car	OW rdiac or re	Sprin espîratory arre	g Rdest, shock, or hea	art Approximate Interval
/Medical Examiner	ì	failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovasc	ular Dise	ase					Between Onset and Death
Examiner	1	or condition resulting in death) Due to (or as a consequence of):							
And the second	힐	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause							
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leath ce attence for use	Sici	1 Yes 2 No 9 Unknown Pregnant at time of death Unknown	5 Othe	er (Specify)					.8
		Part II. Other significant conditions contributing to death but not resulti	ng in the un	derlying cause giv	ren in Part	II.			bute to the cause of death?
ords, P.O. Iw requires that as been signed b.	Completed by	Emphysema		 					Probably 4 Unknown
Cord	틟					_	24a. Was a autop	sy p	Vere autopsy findings available prior to completion of cause of leath?
tal Rec		25. Was case referred to medical		26.Place o	f Dooth (C	Phonic and	1 Yes	2 N 1	Yes 2 No
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Division of Vital Records, pital or Attending Physician: The law requirement after death. After this certificate has been sifilled in by the funeral director, page 2 should be a fine or the funeral director, page 2 should be a fine or the funeral director, page 2 should be a fine or the funeral director, page 2 should be a fine or the funeral director, page 2 should be a fine or the funeral director, page 2 should be a fine or the funeral director, page 2 should be a fine or the funeral director, page 2 should be a fine or the funeral director, page 2 should be a fine or the funeral director and the fine or the	Certification:	3 Suicide 6 Could not be determined (Specify)	rarm, street,	, ractory, office but	iaing, etc.		or Town, S		er or Rural Route Number, City
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To the Ho within 24 To the Fo	Medical	one) Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier/	investigatio	29c. License		urred at th	ne time, date :		ed (Month, Day, Year)
	=	(C Vis la MI)		O.C.M				June 27, 20	
1	-	30. Name and address of person who completed cause of death (Item 23a))		-				
			11 Penn S	Street, Baltimo	ore, MD	21201			
Sta Registr	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Book	2					
DHMH 17 Rev 1/20		OUL U Q LOVO	RIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician July 2, 2006 Mary Petronella Redding 11:25 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1828 Hanford Road Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 20,1923 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Days 83 217-12-5095 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits Rosedale Maryland Baltimore 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1828 Hanford Road 21237 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No 1 Never Married 2 Marned 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 yr 's College (1-4or 5+) Office Worker Social Security Admin. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Arthur Sweeney Veronica Hirsch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James P. Redding, Jr. - Son 1828 Hanford Rd. Baltimore, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GaRDENS Of Faith July 7, 2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21214 + Jansoch Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ABETES (or as a consequence of): 2kinsun> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): 1BRILLATION that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? VERA MAERAL VASCUVAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 \ No 1 ☐ Yes P☐No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 15 Residence 6 Other (Specify) 1 ☐ Yes P☐No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-48025 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (INESAC) ANE, BALTIMORE, MD 21237 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 5 2006

Registrar DHMH 17 Rev 1/2001

within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

To the Hospital of within 24 hours a To the Funeral D

Funeral

Director

r then "naturel", or Iteme 23s or 28s-f show the Medical Examinar must be notified at

Physician /Medical

Examiner

attending physicien and for use as the burial-transit

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

death with the Maryland

State of Maryland / Department of Health and Mental Hygiene 20927 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JULY 2, 2006 Year **Physician** CHARLENE HACKETT SCHUMCHYK 2:05P M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE GILCHRIST HOSPICE CENTER TOWSON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 8. Date of Birth (Month, Day, Yes 5-4-1927 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Months 1 ☐ M 2 🔀 F TEXAS 79 Yrs. 466-24-8883 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hyglene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28e-f ahov any injury or other traumatic event, the Madical Extra Instrument to notified at once. MD BALTIMORE ROSEDALE 1 □Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21237 U.S.A. 2027 LONGVIEW AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-0036 Specify: WHITE Š 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
HOMEMAKER 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) (DAINES) HACKETT DOROTHY CHARLES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) C. DIANE LEVIN/DAUGHTER 904 A. CHESTNUT RIDGE DRIVE JARRETTSVILLE, MD 21093 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 MOther (Specify) ENTOMBMENT GARDENS OF FAITH CE. 7-6-2006 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVENUE ROSEDALE. MD 21237 23a: Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart laiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) week **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Physician/Medical Examiner Due to (or as a consequence of): Srhumchyk Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? ō 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No ٩ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 - Homicide within 24 hours e To the Funeral C McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 025205 chules St. Belto. md 2,200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Binc 6701 Rile 31. Date liled (Month, Day, Year) 32. Registrar's Signature State JUL 0 5 2006 Registrar

2:05pm

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	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last) Phylls Margaret 4a. Facility Name (If not institution, give street and number)	Stekns	m, or Location of Death	Date of Death Month -2	Day Year 9 - 6	3. Time of Death 07,20 AM	
	Funeral Director	eı	Battimore washington	7 e livea Glen	Burnie ear If Under 24 Hrs. 8 ays Hours Min.	Date of Birth	Anne / par) 9. Birth Con	Arunde/ pplace (State or Foreign aryland	
	faryland	٥٢	Usual Residence of Decedent 10a. State 10b. County 10c. 0	City, Town or Location Glen Burnie			1730	10d. Inside City Limits 1 ☐ Yes 2 🗹 No	
	h with the h 23a or 28a-i	al Directo	10e. Street and Number 7735 Donegal Bay Drive	10f. Zip Co	21060	10g.	Citizen of What Co.		
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "neturel", or Iteme 23a or 28a-f ehow important: if Item 27 is marked other then "neturel", or Iteme 23a or 28a-f ehow any follury or other treumatic event, the Medical Examination must be notified at angle.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 MWidowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes, Give Year or Dates:	U.S. 13. Was Decedent If Yes, specify 1 ☐ Yes 2 ☑	of Hispanic Origin? (Speci Cuban, Mexican, Puerto Ri No Specify:	fy Yes or No- can, etc.)	14. Race - Amer Black, White Specify: Wh:	e, etc.	
21215-0	d within 72 ho giene. or then "netur the Medicel.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary(Secondary (0-12) College (1-4or 5+)		ccupation one during most of working stired) Specialist		Ept. Of De		
Maryland 2121	should be file and Mental Hy marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) Karl Schloss		18. Mother's Name (i	Lingner	ſ		
	and 2 st Balth and n 27 is n		19a. Informant's Name/Relationship (Type, Print) Tina N. Stevens (Daughter)		reet a <i>nd N</i> umber or Rural F ane, Cambridg				
altimore,	Pages 1 anneat of He		1 ■ Burial 2 □ Cremation 3 □ Removal from State	Place of Disposition (Name comptery, crematory or other	place)		. Location - City or 1		
Baltin	permit. Pa Departme Important any Injury		4 Donation 5 Other (Specify) G1 21. Signature of Funeral Service Licentee	Len Haven Mem 1 22. Name and A MS Sully 32841MS	Park 07-03- Dark 07-03- Polyniak Fur Intain Road,			, Maryland and 21122	
4.			23a. Part 1. Enter the disease, or complications that caused the de stock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death	
	Physician /Medical Examiner		disease or condition resulting in death) Due to (of as a conse	equence of):	ntarctio	7			
	bed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfug Cause (Disease or injury	equence of):	y thromb				
2,0978	icate be executed physicien and s the burial-transit	dical Examiner	that initiated events resulting in death) Last c. Due to (or as a conse		two-typ.	elwo			
O. Box 6	auth certif attending for use as	Physiclan/Med	in the past 12 moeths?	23c. If yes, outcome of pregnancy the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)					
rds, P.	wrequires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not re Factor Z deficience	. /	the cause of death?				
Division of Vital Records,	sicion: The law re scerificate has be irector, page 2 shu	Completed	Hypertension Morbid Obesity			24a. Was an autopsy performed 1 ☐ Yes 2 ☑	? prior to co	topsy findings available ompletion of cause of	
<u> </u>	ysicien s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 D No Hospital: 1 Inpatient 2	DER/Outpatient 3□ DOA	26. Place of Death (Cither:		6 □Other (Spec	(6.)	
sion of	To the Hospital or Attending Physicien: The within 24 hours efter death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: T	27. Manner of Death 1	28b. Time of Injury M	Noury at Work? 1 Yes 2 No	d. Describe how in			
Ω	ial or Attendes setter deatles I Director:	Certifi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined building, etc.)	t home, farm, street, factory, off cify)	ice 28	f. Location (Street City or Town, St	and Number or Rui ate)	ral Route Number,	
	To the Hospital within 24 hours e To the Funeral is completely filled	edical	29a. Certifier (Check only one) 1	nowledge, death occurred at the ination and/or investigation, in	ne time, date and place, and my opinion, death occurred	d due to the cause at the time, date a	o(s) and manner as and place, and due	stated. to the cause(s)	
	To the To the Comp	Ž	29b. Signature and file of certifie		cense number		Date signed (Month		
	16		30. Name and address of person who completed cause of death (Itr	lem 23a) (Type, Print)	043303 Ritchie	0	6-29	-2006	
	Sta	to.	Jeffrey Atkinson M 31. Date filed (Month, Day, Year) Registrar's Sign	10 8028	Ritchie	Huy 1	Jasade.	ng MO	
	Registi	_	JUL 0 5 2006 Resur	* posti		•			

			1 - For State Registrar	tate of Maryland / Depa	artment of H <i>rtificate of I</i>			4000	20929
	_		Registrar 1. Decedent's Name (First, Middle, Last)		illicate of t		Reg. N 2. Date of Death	0,	3. Time of Death
	Physicia /Medic		Florence 1	1. Smith			JULY D	1, 200	6 1:00 AM
	Examin		4a. Fecility Name (If not institution, give stree Saint Joseph Me	et and number) dical Center	4b. City, Town, or	Location of Death Towsor		c. County of Dea Bal	timore
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. E	B. Date of Birth (Month, Day, Yea	9. Bir	thplace (State or Foreign
	Director		213-18-05 8 1 M	2MF 89 Yrs.	Months Days	Tiours William	12-13-16		ryland
	/land		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-f eh	ctor	MD	Balt	imore	<u>ر</u>			1 [2 (√yes 2 □ No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Co	ountry?
	e 23a	eral		Was Decedent Ever in U.S. 13.	212	239	(SA	dona la dia
336	within 72 hours after deeth with the Maryland iene. rithen "naturei", or iteme 23a or 28a-f ehow the Medical Examinat must be motified at	by Funeral		Armed Forces?	was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	ispanic Origin? (Spec in, Mexican, Puerto Ri Specify:	лу Yes or No- ican, etc.)	14. Race - Ame Black, Whi	
21215-0036	72 hor	Completed	15. Decedent's Educati	on 16a. Dece	dent's Usual Occupa	ation during most of working	16b.	Kind of Business	/Industry
121	within ene. then "	mp[11. / / 3	College (1-4or 5+)	DO NOT use retired			Drive	4
9	filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Last)		omes	18. Mother's Name (First, Middle, Maide	n Sumame)	70
Maryland	Mental Mental arked o	To B	JOHNR. Willia	. N S		DILOGAL	Clagas	H0.	
lary	2 should and Men is marks sumatic		19a. Informant's Name/Relationship (Type,		ng Address (Street	and Number or Rural	Route Number, City	or Town, State,	Zip Code)
_	ges 1 end 2 should be filed t of Heelth and Mantal Hyg If item 27 is marked othe or other traumatic event,	1	Barbara Smooth	Grandlaugh 13	312 Lb0	Chourne	Ave B	alto M.	D 21239
OC	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rem	oval from State cemetery, crea	matory or other plac	(0)	1	Location - City or	
Baltimore ,		. 1	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Day to . Wa	Hioual Ce	Metery 7/	6/06 D	HIMO	re, MA
Ã	permit. Depertr Importa eny inje		Bo Clata	m01363	1905 ()	OLKTIL	·32 140	JAMO JSU MD 2	212
ı			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of	ons that caused the death. Do not enause on each line.	ter the mode of dyin	g, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	CONGESTIVE HEA	RT FAIL	JRE			Onset and Death
	/Medical Examiner		and the second s	Due to (or as a consequence of): ISCHEMIC CARDI	OMYOPATI	ΗY			
	2	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			-		
6	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	Duals (assessment)					
68760,	ficate be executed physicien and sthe burial-transit	al E		Due to (or as a consequence of):					
687	T 70 m	edical	d						
Вох	death certif e attending id for use as	an/M	230. Was decedent pregnant	If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 3 □	⊒Ectopic pregnancy	(23d. Date of de	,
o.	0 0 0	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐ Pregnant at time of death 5 [9☐ Unknown	Other (specify)			Month	Day Year
a	The law requires thet the steep size the steep size of the sage 2 should be detached.	by Pi	Part II. Other significant conditions contrib	uting to death but not resulting in the u	inderlying cause give	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?
brd	w require been signated should t		RENAL FAILURE				1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown
of Vital Records,	he law i s hes be ige 2 sh	Completed	DEMENTIA				24a. Was an autopsy	prior to	utopsy findings available completion of cause of
alF							performed? 1□ Yes 2♠ N	death? 0 1 ☐ Yes	2 □ No
Ζij	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hosp	oital: 1 ☑ Inpatient 2 ☐ ER/Outpatien	nt 3 DOA Oth	er:	Check only one) 5 \[\text{Residence} \]	0 TO: (C-	
	ig Phy ter this neral o	$\vdash_{\mathbb{N}}$	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time o	III. 3L DOA	4 🗆 Nursing Homi	d. Describe how inj		city)
Sior	Attending I r death. ector: After by the funer	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be ☐	(Works, Day 70a) Injury		Yes 2 □No			
Division	el or Attence elter death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28	f. Location (Street a City or Town, Sta		ural Route Number,
	To the Hospitel or At within 24 hours effer of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 \(\infty\) Certifying Physici (Check only one)	an: To the best of my knowledge, deat On the basis of examination and/or in and manner stated.	th occurred at the tin	ne, date and place, an pinion, death occurred	d due to the cause(d at the time, date a	s) and manner as nd place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. Licenso	e number	29d. D	ate signed (Mont	h, Day, Year)
			1	5		7254		7111	06
	17		30. Name and address of person who comp			TOUCOS	MARIA AS	D 0400	,
	Sta	te	BOON POH LIM, M. 31. Date filed (Month, Day, Year)	32. Registrar's Signature	DISTAR	I OMPON*	MHKYLHN	ח קוקמי	4
	Registr	ar	.111 0 5 2006	32. Fegistrar's Signature	22161				

			1 - For State Registrar	State of Ma	aryland /				ealth a		lental Hy	/giene	006	20930
	Physici	an	1. Decedent's Name (First, Middle, Last)								Date of D Month	eath Day	Year	3. Time of Death
	/Medic			Aaron	Floyd	Sin	nmons				6	30	2006	9:30 рм
	Examir	ner	4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of	of Death		4c. C	county of Death	
2		, Marie	5916 Franklin Ave				Ba1						/A	
38.	Funeral Director		5. Social Security Number 6. Security Security Number 220-64-8483	7. Ago	50	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of B (Month, D	irth lay, Year) 3–1955	Cou	place (State or Foreign ntry) Md
	land Dw		10a. State 10b. County		10c. City, To	wn or Loc	cation							10d. Inside City Limits
	the Mary 28a-f eh	Funeral Director	Md N/	Α	Balte	0	10f. Zip					10- Chi-		X Yes 2 No
	a or	급	5916 Franklin Ave	nuo Ant	2 C			2120	7				en of What Cou	ntry ?
	eath marga	eral	11. Marital Status	nue Apt 12. Was Decedent		13 W				ain? (Sne	cify Yes or N	U S	A 1. Race - Ameri	can Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23a or 28a-f ehow importent: if item 27 is marked other then "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at ance.	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2X 1 tf Yes, Give Year or Dates:					Specify:		ecify Yes or N Rican, etc.)		Black, White,	etc.
Ö	2 hou	ed	15. Decedent's Edu	cation	16	ia. Deced	ent's Usua	al Occupa	ition			16b. Kin		dustry Unk
215	n n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5		(Give k	kind of wor OO NOT us	rk done d se retired,	<i>luri</i> ng mos)	t of worki	n <i>g</i>			Olik
212	d within giene. rr then "	E	10th grade	College (1-401 5	N/A	Tr	uck	Driv	er					
	e filed Il Hygin other	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle	e, Maiden S	iumame)	
lar	Aental Aental rked c	To E	David Simmons,Jr						Jea	an Sy	re			
Maryland	nd 2 should lith and Men 27 is marke r traumatic		19a. Informant's Name/Retationship (Ty Ronnie Simmons -		15				rs Av			ber, City or	Town, State, Zip	Code)
ē,	s 1 a f Hea item othe		20a. Method of Disposition		20b. Place	of Dispos		ne of			Dal		ation - City or To	own, State
Ę	Page ent o nt: if ry or		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	King		,	,	1	7-6-2	006	Ran	dallsto	wn. Md
Baltimore,	permit. Departm Departm Importer eny Inju		21. Signature of Funeral Service Licens	Mari	2		Name an	d Addres	s of Facilit	y Ma	rch F/	H We		
			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only or	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									Approximate Interval Between	
8760,	Physician /Medical Examiner physician and physician are p	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Bud	a consequence from the consequence of the consequen	e of):	otic sus p	Ce n le	esdi Dis	o Vi	se se	ar Di	sease	Onset and Death
.O. Box 6	ath certific tending p	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	of pregnancy 2 ☐ Fetal dea		Ectopic pr Other (sp					23	id. Date of delive	ery Day Year
Records, P.	uires that the de i signed by the a id be detached f	by	Part II. Other significant conditions con	ntributing to death b	ut not resulting	in the un	derlying c	ause give	n in Part I	•		tobacco us		he cause of death?
Ö	w requir been si should I	ete									24a. Wa			Control of the Contro
al Re		Completed									auto	ormed?	prior to co death?	opsy findings available impletion of cause of
Vital	iciar certif ecto	Be	25. Was case referred to medical examiner?	lospital:				Othe	_		(Check only			
ō	ding Physician: After this certification funeral director,	. To	1 Tyes 2 No 27. Manner of Death	1 U Inpatie	nt 2 ERV	Outpatient Time of		70	4 🗆 140				Other (Specif	ý)
u	gr eff	lo	1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da)	Year)	Injury	M	8c. Injury Work	.? ∕es 2 🗀		28d. Describe	now injury	occurred	
Division	or Attending after death. Dirsctor: After in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, c. (Specify)	farm, stre					28f. Location City or To	(Street and own, State)	Number or Rura	al Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Co	29a. Certifier (Check only one) 1 Certifying Phy. 2 Medical Exami	sician: To the best of the basis of and manner sta	examination a	ge, death and/or inv	occurred estigation,	at the tim	e, date an inion, dea	d place, a	and due to the	cause(s) a	nd manner as s lace, and due to	tated. the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier	,			290	. License	number			29d. Date	signed (Month,	Day, Year)
	F 3 F ŏ		Dane	esan	40		.7	21	649					
	7		30. Name and address of person who co	empleted cause of d	eath (Item 23a	(Type, F	Print)	LK	5N	10 1	No.	BALT	MORF	2006 M021229
	Sta Regist		31. Date filed (Month, Day, Year)		ar's Sigriature	, ,	0			y	,		-,	

DHMH 17 Rev 1/2001

		1	For State Registrar	State	of Maryla		artment of F tificate of	lealth and M Death		ene 2006	20931		
			Decedent's Name (First, Middle		Date of Death Month	Day Year	3. Time of Death						
	Physicia /Medic	_	CAS	IMIR PA	TRICK	SAINTO	ROSS, S	R.	JULY 1	, 2006	10:55P™		
	Examin		4a. Facility Name (If not institutio	_				r Location of Death		4c. County of Death			
			2505 SYKESV				WESTMINSTER If Under 1 Year If Under 24 Hrs. 8, Date 0		0. Data of Righ	CARROL	nplace (State or Foreign		
	Funeral		5. Social Security Number	6. Sex 1 ½ M 2 ☐ F	7. Age (in yr	s. last birthday) 76 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	(ear) Coi	uintry)		
	Director		216-24-7491 Usual Residence of Decedent	<u> </u>		76		J	8/5/19	129 MAR	YLAND		
	land	-	10a. State 10b. County		10c. C	City, Town or Lo	cation				10d. Inside City Limits		
	Many feet	ţō	MD CARI	ROLL	V	WESTMI	NSTER				1 ☐ Yes 2X No		
	death with the Maryland ime 23a or 28a-f ahow rmust be notified at	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	untry?		
	th wit		2505 SYKES	/ILLE RD			211			USA			
	dea	Funerai	11. Marital Status		cedent Ever in orces?	U.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White			
9	or to		1 Never Married 2 Mai	ried 1 XYes	Forces? 2 No KO Sive KO Dates: CON	REAN	1□Yes 2X No			Specify: TAT	HITE		
ë	within 72 hours after ene. then "naturel", or ite ite Medical Exercine	d by	3 Widowed 4 □ Divorce		Dates: CON	EDICE	dent's Usual Occup	ation	11	6b. Kind of Business/			
7	n 72 nat	Completed	(Specify only highe	nt's Education est grade completed		(Give	kind of work done DO NOT use retire	during most of works	ing	ob. King of Eddinosa			
12	withi ene.	E C	Elementary/Secondary (0-12)	College	(1-4or 5+)	I	OLICE C	FFICER	L	AW ENFOR	CEMAN		
0 0	filed Hygid Sther ant,	0	17. Father's Name (First, Middle	Last)				18. Mother's Name					
<u>a</u>	Mental Mental arked o	To B		E	MIL SA	INTCRO	SS	ANNA	GEN	TILE			
Maryland 21215-0036	& BEE		19a. Informant's Name/Relation	ship (Type, Print)		1	-		al Route Number, City or Town, State, Zip Code)				
	1 and 2 Health a tam 27 is		SONNY SAINTO	ROSS -	SON	_		ARK RD.,			21157		
ore	of He of He fiten	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from	n State		matory or other pla	ce)		Oc. Location - City or			
<u>Ĕ</u>	Pages ment of ent: if it ury or o		4 Donation 5 Other (Specify)	EVE			ARDENS 7		FINKSBUR			
Baltimore,	permit. Pages Department of h importent: if its any injury or o'		21. Sunatura of Efferal Service	Licensee				ess of Facility FLI MAIN ST.		FUNERAL INSTER,	HOME MD 21157		
			23a. Part1. Enter the disease, of shock, or least failure. Lis	r complications tha	t caused the de						Approximate Interval Between		
	Physician		Immediate Cause Final disease or condition	(0,111) 0,110 0,110 0,11	PAD	6-10 1	mouler	1 au	ident		Onset and Death		
	/Medical		resulting in death) Due to (or as a consequence of):										
	Examiner												
	= \1/a	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	Due to (or as a consequence of): Sudden Candill dooth Due to (or as a consequence of): Hyperlip! domin								
	execute on and rial-trans	Examiner	that initiated events resulting in death) Last	c. Due t	o (or as a cons	equence of):	enall	ic app	XL.				
8760,	cate be executed physicien and the burial-transit	a E			Hung	phinip	(pmi						
687	death certificate be e attending physicie ed for use as the but	edical		d	14/	The state of the s							
Box (leath certific attending p	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	outcome of preg	gnancy	_			23d. Date of del	ivery		
	death a atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 <u>□</u> Pre	e birth 2∏Fe ignant at time o		_Ectopic pregnanc _Other (specify) _	у		Month	Day Year		
P.O.	that the de ed by the detached	hys	9 Unknown	9□ Uni	known		11.5-300		94.5		-		
	res tha	by P	Part II. Other significant condit	ions contributing to	death but not r	resulting in the t	inderlying cause gr	ven in Part I.		acco use contribute to	.		
ğ	w require been sig should b								1 ☐ Ye	s 2 □ No 3 □ Pr ———	obably 4 Unknown		
of Vital Records,	a 2. C1	Completed							24a. Was an autopsy	prior to	topsy findings available completion of cause of		
Œ	The ete	5							perform 1 ☐ Yes 2	ed? death? No 1 ☐ Yes	2□ No		
/ita	sician: T certificet rector, pa	Be	25. Was case referred to medic examiner?				100		h Check only one)			
7	w =	ပ္	1 ☐ Yes 2 No			ER/Outpatie	nt 3L DOA		ome 5 Reside	nce 6 Other (Spe	cify)		
N C		ion	27. Manner of Death 1 Natural 5 ☐ Pend	ing (M	te of Injury onth, Day Year,	28b. Time o	Wo	rk?]Yes 2 □No	200. Describe no	w inquiry occurred			
Sic	Page 1	icat	3 Suicide 6 Could		ce of Injury - A	t home, farm, st	reet, factory, office	1103 2	28f. Location (Str	eet and Number or Ri	ural Route Number,		
Division	2 2 2 2	Certification:	4 Homicide		ilding, etc. (Spe				City or Town	State)			
_	d hours unerel	edicai C	(Check only 2 Medica	I Examiner: On the	basis of exam					isa(s) and menner as te and place, and due			
	To the P within 2 To the C	Med	29b. Signature and fitte of Certifi		anner stated.		29c. Licen	se number	29	d. Date signed (Mont	h, Day, Year)		
	5 3 5 2		> Div	Ne sino	Phy.	sician	D	22663		7-3-6	06		
,	(V)		30 e and address of person	n who completed ca	ause of death (I	ltem 23a¥(T <u>v</u> pe	Print)	h .		L . /-	MD-21157		
	H1,		Nagn 9 3	were	mo	. 421	2 Kills	c Rd.	West	misler	MO-21157		
	St	ate	31. Date filed (Month, Day, Yea		Registrar's Si	gnature							
	Regist	rar	JUL 05	2006	MILLES J	15 Gos	when						

DHMH 17 Rev 1/2001

		4	State of Maryland	d / Department of H			211116	20932
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of t	2.1	Reg. No	y Year	3. Time of Death
	Physicia /Medic		Dolores May Streib		-	Month Da	2006	2:052 M
	Examine		4a. Eacility Name (If not institution, give street and number)	4b, City, Town, o	Location of Death	40	County of Death	V0
	Funeral		5. Social Security Number 6. Sex 7. Age (n yrs. li	ast birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. I Hours Min.	Date of Birth	9. Birth	blace (State or Foreign
	Director		220-18-4380 1□ M 2♥F 81	Yrs. Months Days	Mo	Date of Birth (Month, Dey, Year) LY 4, 192	5 Mary	l'and
	land ow	-	Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Location				10d. Inside City Limits
	a-f eh	to	Maryland Baltimore	Parkville				1 Tyes 2 No
	ours after death with the Maryland ret; or iteme 23e or 28e-f show Examiner must be notilised at	Director	10e. Street and Number 3411 Maple View Way	10f. Zip Code	21234	10g. Ci	tizen of What Cou U.S.A	•
	me 234	Funeral	11 Marital Status 12. Was Decedent Ever in U.	S. 13. Was Decedent of H	lispanic Origin? (Specify an, Mexican, Puerto Rica	Yes or No-	14. Race - Ameri Black, White,	can Indian,
S 50	or ite		1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates:	1 ☐ Yes 2 🎗 No		, 0.0.7		rite
07 e :	72 hours after netural, or ite	ed by	15. Decedent's Education	16a. Decedent's Usual Occup	pation	16b. k	Kind of Business/Ir	dustry
000	within 72 ene. than "ne	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of working d)		Own Ho	ma
421	Hygier Hygier other th	င်	11 17. Father's Name (First, Middle, Last)	Homemaker	18. Mother's Name (Fi	irst, Middle, Maidei		me
lane	Mental arked o	To Be	George A. Stivers		Mary	A. Ben		
Mary	2 short	1 13	19a. Informant's Name/Relationship (Type, Print) Charles Streib (husband)	19b. Mailing Address (Street 3411 Maple V				
e 6	1 and Health tem 27		20a, Method of Disposition 20b. P	Place of Disposition (Name of emetery, crematory or other pla			ocation - City or T	
大豆	Pages nent of int: If it iry or o			en Haven Mem'l	Park 7/8/20			
# Baltimor	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natur any injury or other traumatic event, tra Madical once.		21. Signature of Funeral Service Licensee		ess of Facility Schir ir Rd., Bali			es 21236
			23a. Part1. Enter the disease, or complications that caused the deatl shock, or heart failure. List only one cause on each line.	<u> </u>		espiratory arrest,		Approximate Interval Between Onset and Death
	Physician		regulting in death)	gan tailur	و			
	/Medical Examiner		MRS A	infection				
	Pa 🔖 is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	uence of):	A laure of	- vl-	.)_	
	and and I-trar	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. 100000	nt lower of	ide uso	7	
8760,	9 × 6	cal	Co. Irviunocompron	nise status - 3	rome stero	arterit	13	
9 x c	nding puse as	n/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta				23d. Date of delin	
P.O. Box 68	ne death the ette hed for	sicia	in the past 12 months? 1 Yes 2 Umo 9 Unknown 9 Unknown		.,		Month	Day Year
	that the the ned by detac	y Ph	Part II. Dther significent conditions contributing to death but not res	ulting in the underlying cause g	ven in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ords	equires en sig ould be	ted b	Giant Cell Arteritis			1 ☐ Yes		obably 4 □Unknown —
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the ettending ph completely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med				24a. Was an autopsy performed? 1 ☐ Yes 2	death?	opsy findings available ompletion of cause of
ital	ian: T rtificate ctor. pa	Be Co	25. Was case referred to medical examiner?		26. Place of Death (C		40 1 12 100	20.10
of V	Physic this ce al direc	ုင္	1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ☐	Ervoulpatient 3 DOA	her: 4 Nursing Home	5 Residence		ufy)
uo	ding I th. : After s funer	tlon.	27. Manper of Death 1. Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury Wo	ork? Yes 2 \ No		,,	
isisi	r Atter ter dea frector	ertification;	000.14-41-	ome, farm, street, factory, office	281	Location (Street and City or Town, Sta	and Number or Ru ate)	ral Route Number,
۵	pital o	C	29a. Certifier 1 Certifying Physician: To the best of my kni	owledge, death occurred at the	ime, date and place, and	d due to the cause	(s) and manner as	stated.
	he Hos in 24 h he Fur pletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.					
	To t Con	Σ	29b. Signature and tifte of certifier	A P I	se number	290.	Date signed (Mont)	26
	1		30. Name and address of person who completed cause of death (Ite	m 23a) (Type, Print)				
_	V		Dr. Corina Negrescu,	9000 Frank	lin Squar	e Drive	e, balt	0, MU. 2123
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Sign	& Sparle	f			

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State o	f Marylar		artment o			d Mental Hy	giene Reg. No.	2006	20933
	\$ 5 L		1. Decedent's Name (First, Middle, La	st)					-	2. Date of De Month	ath Day	Year	3. Time of Death
. %	Physici /Medio			Gerald	Eugene		Sprous	se, S	Sr.	June	. 29	2006	5:04A
	Examir		4a. Facility Name (If not institution, give	e street and nu	mber)		4b. City, Tov	vn, or Loc	ation of D	eath	4c.	County of Death	
	· ·		7809 Eastdale				Col	gate				Balti	more Co.
	Funeral		5. Social Security Number 6. S	Sex SZM 2□F	7. Age (In yrs.	last birthday. Yrs.	Months D		Under 24 ours N	Hrs. 8. Date of Bir Vin. (Month, Da	th ly, Year)	9. Birth	place (State or Foreign ntry)
**	Director		214-54-4957 Usual Residence of Decedent		57	115.				Nov.	5,194	8 Sout	h Carolina
6	*		10a. State 10b. County		10c. Ci	ity, Town or L	ocation						10d. Inside City Limits
Man	4	ō	Maryland Bal	timore						Colgate			1 ☐ Yes 2√TNo
4	28a	rec	10e. Street and Number				10f. Zip Co	de			10g. Citiz	en of What Cou	ntry?
, in	380	0	7809 Eastdale R	oad				21	224		Uni	ted Sta	tes
1215-0036	me 2	by Funeral Director	11. Marital Status	12. Was Dece	edent Ever in U	J.S. 13.	Was Decedent	of Hispan	nic Origin	? (Specify Yes or No uerto Rican, etc.))- 1	4. Race - Ameri	
ي ي	or ite	F	1 ☐ Never Married 2 🔀 Married	1 Yes	25 No		1 ☐ Yes 2 ☑			ueno Alcan, etc.)		Black, White,	
ဥ	E E		3 Widowed 4 Divorced	Year or D	ates:		10 165 20	-140 SL	oecify:			Specify: W.	hite
2	natu	Completed	15. Decedent's E (Specify only highest gra			(Giv	edent's Usual O	one durini	g most of	working	16b. Kir	nd of Business/In	dustry
12	P 9 9	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	etired)		J			
Maryland 21215-0036	her t		12 Years 17. Father's Name (First, Middle, Last	1		Ele	ctricia		Mashada	None (First Middle		eel Ind	ustry
anc anc	d of	Be		,				18.		Name (First, Middle,		Sumame)	
2	J Mer nark	T ₀	Frank Sprouse	Torre Colon		401.44				ah Inglet			
Mai	h and 7 ie n traun	1 9	19a. Informant's Name/Relationship (**	4.E.~\					r Rural Route Numb			
e, 1	Healt em 2 ther	1 3	Mrs. Rohamma Spr 20a. Method of Disposition	ouse (w		_	osition (Name o		Road	Baltimon		aryrand ation - City or Te	
Baltimore,	or or		1 Burial 2XXCremation 3		State	cemetery, cre	matory or other	place)	1				500.0
tin	rtmer		4 Donation 5 Other (Special		Hi					/3/2006	Tow	son, Ma	ryland
Bal	porturn: region along should be along waryant be porturned to the porturn of the properties of the pro		21. Signature of Funeral Service Lice	1500	en		2. Name and A Juda-Ruc 7922 Wi			l Home of Dundalk,	Dund Mary	lalk, In land 2:	c. 1222
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that o	aused the dea	th. Do not er	ter the mode of	dying, su	ich as car	diac or respiratory a	rrest,		Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	3	adde	c C	RUCE						Onset and Death
	/Medical xaminer		resulting in death)	Due to	(or as a consec			-					7.2
	.xaiiiiiei		Sequentially list conditions,	b									
7	مرية ا	Ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to	(or as a sonsec	quarica of):							
41.00	and -tran	Examiner	that initiated events resulting in death) Last	C. Due to	(or as a consec	suance of							
8760,	cien			D08 10	(Or as a consec	querice or).							
. Box 68760,	physicien and sthe burial-transit	dlcal		_ d.					_				
9 xo	inding pure as	Physician/Me	IF FEMALE:	23c. If yes, out	come of pregn	ancy					Π.		
Bo	ettending for use as	lan	23b. Was decedent pregnant in the past 12 months?	1☐Live b	ointh 2 ☐ Feta	al death 3	Ectopic pregn				2	3d. Date of delived Month	ery Day Year
o g	ed by the e	yslc	1 ☐ Yes 2 ██\o 9 ☐ Unknown	9□ Unkn	nant at time of o	death 5	Other (specif	у)					•
م ا	ad by detac	유	Part II. Other significant conditions	contributing to d	eath but not res	sulting in the	inderlying caus	ni nevin e	Part I	23a Did t	obacco us	se contribute to t	he cause of death?
ords, P.	s been signed t should be det	d by	•	-		Jan. 11. 12. 12. 12. 12. 12. 12. 12. 12. 12		5 g. (5) (1)			Yes 2□	_	
Ö		ete								-		-	, ,
Jec B	ha:	Completed								24a. Was	osy	prior to co	ppsy findings available mpletion of cause of
<u>a</u> <u>n</u>	pate							-		1 ☐ Yes	2000	death?	2□ No
of Vita	this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:						Death Check only of	one)		
o d	w 5	2	1 Yes No 27. Manner of Death	28a. Date	Inpatient 2	28b. Time			Nursir			Other (Specif	(y)
5	After fune	5	1 Aatural 5 ☐ Pending	(Mon	th, Day Year)	Injury	M 286.	Injury at Work? 1 Yes	2 DNo	28d. Describe	now injury	occurred	
vision	deat ctor: / the	Cal	2 Accident investigatio 3 Suicide 6 Could not b	e Jee Blees	of Injuny - At h	ome form o	reet, factory, of		2 🗆 140	29f Location (Stroot one	I Number of Cum	al Route Number.
5	Dire Dire	Certification:	4 Homicide determined	buildi	ng, etc. (Speci	ity)	reet, ractory, or	IICe		City or To	wn, State)	Number or Hura	ar Houte Number,
- i	24 hours e Funerel l		29a Certifier Certifying Pl	ysician: To the	has of my kn	civilados dan	th occurred at th	o tima di	ate and a	lane, and due to the	enie ale)	and manner as a	644.27
2	24 h Fur etely	edical	(Check only 2 Medical Example)	niner: On the b	asis of examination	ation and/or i	vestigation, in	my opinio	n, death o	occurred at the time,	date and	place, and due to	the cause(s)
į	within 24 hours efter death. To the Funerel Director: After the completely filled in by the funeral	Me	29b. Signature and title of certifier				29c. Li	cense nur	mber	_	29d. Date	signed (Month,	Day, Year)
)	- > 0		Vamual()	enne	Da n	`		440	576		11	30/06	
	t,		30. Name and address of person who	completed caus	e of death (Ite	m 23a) (Type	Print)	, ,	. , 0		19	10/ 00	
	10		C 1.	mende	M	1670	01/001	nc s	stre	set Bal	Amo	e mo	21231
4 5	Sta	ite	31. Date filed (Month, Day, Year)	-	legistrar's Sign				•			- / V	1,00,
	Registi		JUL 0 5 20	06	PARS A	K de	ente						

		1 - For State Ragistrar	State of Ma	aryland	/ Depa	artment of rtificate of	Health <i>Deatl</i>	and M h	lental Hy	giene (Reg. No.	2008	20	1931
		1. Decedent's Name (First, Middle, Las	t)						2. Date of De	ath		3. Time	of Death
Physic /Medi		T.e.	one Stever	s Sul	livan				Month June	30,	2006	5:40	PM M
Exami		4a. Facility Name (If not institution, give				4b. City, Town,	or Location	of Death			ounty of Deat		
Funeral		Montgomery Hos 5. Social Security Number 6. Se	7. Ag	Hous e (In yrs. las		If Under 1 Yea	r II Unde	ville er 24 Hrs.	8. Date of Bir	th Year	9. Birt	gomery	r e or Foreign
Director		471-24-1014	⊒M 2(X),F	78	Yrs.	Months Day	Hours	Min.	(Month, Da			intry) innesc	ota
۵ ,		Usual Residence of Decedent 10a. State 10b. County		too Cib.	Town or Lo								
anyia ehov	=			Toc. City,	TOWIT OF EO	Cation						10d. Inside	es 2 🖾 No
he M	Director	Maryland Montgo	omery			104 7: 0-4-	Beth	esda		40.000	(110 - 10		
ti o	급					10f. Zip Code				10g. Citize	n of What Co	untry?	
e 23	Funeral		rland Lane		12.1	Non Decedent of		314	ad. Van as Na		United Race - Ame		s
ite de	Ę	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces?			Was Decedent of f Yes, specify Cu	ban, Mexic	an, Puerto	Rican, etc.))- 14	Black, White		
irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	••		1 ☐ Yes 2X N	Specif	y:		S	pecify:	**1 * .	
ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Heelih and Mentel Hygiene. If item 27 is marked other then "naturel", or items 23s or 28s-f show or other treumatic event, the Maddell Examinar must be notified at		15. Decedent's Ed				dent's Usual Occ				16b. Kind	of Business/	White Industry	<u> </u>
in a	Completed	(Specify only highest gra-	de completed) College (1-4or 5		(Give life. l	kind of work don DO NOT use retii	e during mo ed)	ost of worki	ng			,	
l the state of the	E	Elementary/Secondary (0-12)	1)+)		Seci	etary	7		M	edical	Offic	:e
othys art,	40	17. Father's Name (First, Middle, Last)					1		(First, Middle				
should be nd Mentel merked o	To B	Claude	William S	Steven	S				Moni	ca Fa	ckler		
sho and h		19a. Informant's Name/Relationship (7				ng Address (Stree	and Num	ber or Rura				Zip Code)	
and 2 Belth a m 27 is		Robert B. Sulli	an/ Husba	ind	5	218 Mooi	land	Lane	Bethes	da. M	arvlan	d 2081	4
of He rethor		20a. Method of Disposition		20h Pla	on of Disno	cition /Alama of		C	ate		tion - City or		
Peges nent of l		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1 1.7	emarc	natory or other principle ry	C	2.	1uly 2006	Bet	hesda,	Marv	land
permit. Peges Department of Important: If I eny injury or once.		21. Signature of Funeral Service Licen	see /		22	Name and Add thesda-(thesda,	ress of Fac	liy Robe	ert A.	Pumph	rey Fu	neral	Home/
8858		1	al of	M003	35 Be	thesda,	nevy Mary]	Land 2	0814-3	501	Wisco	nsin A	venue
Physician		23a. Part1. Enter the disease or compositions, or heart failure. List only Immediate Cause (Final	one cause on each III	the death. ne.	Do not ent	er the mode of d	ring, such a	is cardiac o	r respiratory a	rrest,		Approxim Interval B Onset an	ate letween
/Medical		disease or condition resulting in death)	aBreast								-		
Examiner		a seed and a seed as a seed as											
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as	a conseque	nce of):								
icate be executed physicien and sthe burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
e exe	Ä	resulting in death) Last	Due to (or as	a conseque	nce of):								
ate b hysic	dlcal	•	d										
e as	Mec	IF FEMALE:											
w requires thet the death certific been signed by the attending fabout do detected for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal d	eath 3	Ectopic pregnan	су			23	d. Date of del Month	ivery Day	Year
the d	sic	1 ☐ Yes 2 1 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	th 5∟	Other (specify)						,	. 52.
het the day		Part II. Other significant conditions of	ontributing to death h	ut not result	ing in the w	ndarkina causa c	nuon in Dar	•1	23e Did i	obacco uso	contribute to	the cause o	f dooth?
signe d be	l by	•	annia di Gallina	ot not room	ing in the di	ndenying cause g	A COLUMN TO CALL				No 3□Pr		
red mean	Completed												
e law hes i	d E								24a. Was	osy	24b. Were au prior to o	topsy linding completion of	s available cause of
: Th	ပိ								1 ☐ Yes	rmed? 2∭No	death?	2□ No	
kicien: Th	Be	25. Was case referred to medical examiner?	Hospital:			10			(Check only				
this aldii	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 U Inpatie		VOutpatien	I 3 DOA	ther: 4 🗆 I	Nursing Hor	ne 5□Resi	dence 6)	Other (Spec	Cify) Host	pice
ding Physicien: The h. After this certificete h funeral director, page	lo	1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	8b. Time ol Injury	W			28d. Describe	how injury o	occurred		
death death	cat	2 Accident investigation 3 Suicide 6 Could not be		un. At hom	o larm et-		Yes 2[201 Location /	Ctront and	Alumban a O		
or A Direct	Certification:	4 Homicide determined	28e. Place of Inj building, et	c. (Specify)	e, iarm, str	eet, factory, office	•	-	281. Location (City or To	ыгөөг ало г wn, State)	vum <i>oer</i> or Hu	irai Houle Ni	im <i>ber</i> ,
To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending it dempets the funeral director, page 2 should be detected for use as		29a, Certifier 1 Certifying Ph	ysician: To the best	of my knowl	edge door	a annument of the	time data	and place	and dress to the	D2110=1-1	ad ma	atate 4	
24 hí Fun stely	edicai		inar: On the basis of and manner sta	f examinatio	n and/or in	vestigation, in my	opinion, de	eath occurr	ed at the time,	date and p	lace, and due	to the cause	e(s)
o the ithin o the omple	Mec	29b. Signature and title of certifier				29c. Licer	nse numbe	r		29d. Date :	signed (Monti	h, Day, Year)
F 3 F 8		・イイン	\sim	m	6		TO 63 TO						
10		30. Name and address of person who	completed cause of a	leath (Itam 3	(Tune	Print)	D35	635			July 1	, 2006	
10		Joseph Kaplan, 1					d Doo	1-1-11	e Mere	12003	20055		
St	ate	31. Date liled (Month, Par, Year) 06		ar's Sonatu			a RUC	VATTT	e, Har	утани	20033		
Regist		JAF (1.9 5000	A THE STATE OF THE	~ /									

		1	1 - For State Registrar	State of Ma		d / Depa	artmer		ealth ai	nd Me	ental Hyg	giene Reg. No.	_	20935
70	Physici	_	1. Decedent's Name (First, Middle, La	TT						2	2. Date of Dea Month ゴルン	Day	Year 2006	3. Time of Death 06 10 AM
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City	, Town, or l	ocation of	Death		4c. Co	ounty of Death	
1111		"	1001 Fieldsto	ne Place	!			1tim				Ar	ne Ar	
, years of	Funeral Director		218-58-6723	Sex 7. Ag 1 X M 2 ☐ F	6 (In yrs. 1	ast birthday) Yrs.	If Unde Months	Days	Hours	4 Hrs. 8	B. Date of Birt (Month, Day Feb • 1	y, Year)		place (State or Foreign htry)
	and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	/, Town or Lo	ocation						1	0d. Inside City Limits
	a-f eho	ctor	MD Anne A	rundel		В	altin	ore						1 XYes 2 □ No
	with the	i Director	10e. Street and Number 1001 Fieldstone	Place				p Code 21226				10g. Citize	n of What Cour ${f A}$	ntry?
030	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show sumatic event, the Medical Exam par must be redified at	by Funerai	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 XYes 2 II If Yes, Give Year or Dates:			Was Dece If Yes, spo 1 Yes		panic Origi , Mexican, Specify:	in? (Spec Puerto Ri	ity Yes or No ican, etc.)	1	Race - Americ Black, White, Decify: Whi	etc.
N-612	rithin 72 ho ne. nan "naturi nan "naturi	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		5+)	(Give life.	kind of w DO NOT	ual Occupations done duse retired)	ion iring most	of working	9		of Business/In	
71 12	be filed stal Hygi od other event, I	Be	12 17. Father's Name (First, Middle, Last Lloyd B. Stitt	1)		FT	ectri	.cian		•	(First, Middle, Walls	Maiden Su	ımame)	
2	should be and Mental marked o	ပ္	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Addres	s (Street a				er, City or T	own, State, Zip	Code)
Ž	D € N ₽		Marsha L. Stitt	/Wife						lace	Baltin		① 2122	
altimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 le marke any Injury or other treumatic <u>pnce</u> .		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control of Control o	☐Removal from State		lace of Dispo emetery, crei en Haven				July 5 2006			tion - City or To Bumie,M	
Balti	permit. Departm Imports any Inju		21. Signature of Funeral Service Lice	nsee		22	Cha	nd Address rles La 1 Fast	Steve	ens Fu	neral H altimon	ome Ind	C. 1230	
	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		STA	TIC (ter the mo	de of dying	, such as c	ardiac or	respiratory ai	rrest,		Approximate Interval Between Onset and Death 4 YEARS
	Attending Physician: The law requires that the death certificate be executed by right. In death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit of	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as										
O. Box 6	the death certificat y the attending phy Iched for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	death 3	⊒Ectopic ⊒ Other (s	pregnancy specify)				23	d. Date of delive Month	ery Day Year
ds, P	w requires that the de been signed by the s should be detached	Ď	Part II. Other significant conditions	contributing to death b	out not res	ulting in the u	underlying	cause give	n in Part I.			obacco use Yes 2 🗆		he cause of death?
Division of Vital Records, P.O.	The law rec ate has bee page 2 shou	Completed									24a. Was autor perfo			opsy findings available impletion of cause of
Zita Zita	ician: Sertific Sector,	Be	25. Was case referred to medical examiner?	Hospital:				Othe		of Death	(Check only o	опе)		
n of	ng Phys fter this o	on: To	1 ☐ Yes 2 No 27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju	urv	28b. Time of Injury	of	28c. Injury Work	at ?	28	8d. Describe		Other (Special Control of the Contro	(y)
Divisio	5 # 5 E	Certification:	2 Accident investigation 3 Suicide 6 Could not determined	be 200 Place of In	jury - At ho tc. (Specif	ome, farm, st	M reet, facto		'es 2 □ N		8f. Location (City or To		Number or Run	al Route Number,
_	Hospital or 24 hours afte Funeral Dir etely filled in	edical Ce		Physician: To the best iminer: On the basis of and manner st	of examina									
	To the within 2 To the complet	Me	29b. Signature and title of certifier				-	9c. License				29d. Date	signed (Month,	Day, Year)
	7		1. Anurad	hamb.				P150	183			JUL:	4,03,	2006
1	8		30. Name and address of person who	completed cause of	death (Iter	n 23a) (Type	Print)	EENE	ST	BE) CTIME	RE 1	nD-21	1201
· · · · · · · · · · · · · · · · · · ·	St Regist	ate rar	31. Date filed (Month, Day, Year) JUL 0 5	2006 32. Regist	rar's Signa	ature	book	e e					nD-21	

DHMH 17 Rev 1/2001

		1	State of Maryland / Department of Health and 1 per Dr., G857, 07/05/06dhb Death	Mental Hygiei	ne2006 20936
			Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
	Physicia /Medic		Ralph Tims	JUNE	Day Year 12 30 M
	Examin	er	4a, Fagility Name (If not institution, give street and number) 4b. City Town, or Location of Dea 4c. City Town, or Location of Dea 4b. City Town, or Location of Dea 4c. City Town, or Loca	ore	4c. County of Death 9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Wonths Days Hours Min Usual Residence of Decedent		25 S. Corolina
	ryland		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 🗶 es 2 □ No
	the Ma 28a-f	Director	106. Street and Number	10g.	Citizen of What Country?
	72 hours after death with the Maryland netural: or Items 23s or 28s-f show iteal Evaninal must be notified at	alD	6203 Chinauapin Phwy 21239		USA
	ter dea	Funeral	11. Marital Status 12. Wal Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12 No 15 No	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	ural', or	þ	3 Widowed 4 □ Divorced Year or Dates:	100	Specify: Black
215-	nin 72 h	Completed	15. Decedent's Education (Specify only highest grade completed) Elementage(Secondary (0-12) College (1-4or 5+)	orking /	. Kind of Business/Industry
2	filed within Hygiene. Ither then "		124h Merchant Sear	ame (First, Middle, Maid	JOTEP TO WT
land	ould be f Mental H arked of atic eve	To Be	John Issac Tims Bess	sie Ma	Cree
Mary	and and list ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F 19c. Tank	1 2 7	ty or Town, State, Zip Code) 20744 T: WaShINGTON, MD
a)	os 1 and 3 of Health if Item 27 or other tra	1	20a. Method of Disposition 20b. Place of Disposition (Name of	1000	Location - City or T nn, State
Baltimor	Pages tment of I tent: If It jury or o	7	1 Donation 5 Other (Specify)	6/16/06	rounsville, MD
Bai	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address a 22	Rd Ro	16 MD 21212
			23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dynamics shock, or heart failure. List only one cause on each line.	ac or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		
ı	Examiner		Carata Henry For	line	
	patr Para	Examiner	Sequentially list conditions, They like ling to immediate cause. Enter Underlying Cause (Disease or injury)	ATT. F	anline
60,	bate be executed only sicion and the burial-transfit		that initiated events resulting in death) Last Due to (or as a consequence of):	Cult	
6876	certificate b iding physic ise as the bi	edica	d chrome Renet I'm	+ mpuin	4
Box	es that the death certific: igned by the attending pl be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery Month Day Year
P.O. E	that the death ed by the atter detached for u	nysic	#Title past 12 floritis: 4 □ Pregnant at time of death 5 □ Other (specify)		
	requires that sen signed b hould be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. A Frad Franklaum	23e. Did tobac	co use contribute to the cause of death? 2 No 3 Probably 4 Sunknown
Division of Vital Records,		Completed by	Berghral Vamler DIFlare	24a. Was an autopsy performed	
ta	sicien: The law certificate has t irector, page 2 s	a		1 ☐ Yes 2 ☐ eath (Check only one)	No 1 ☐ Yes 2 ☐ No
Į V	Physicien: this certific al director,	To B	examiner? 1 Yes 2 No Other: 4 Nursing	Home 5 Residence	e 6 □Other (Specify)
o uc	ffer nei	:lon:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Yes 2 No	28d. Describe how	injury occurred
visio	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, itate)
Ō	pitel or ours aft erel Di filled in	Cer	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	ce, and due to the caus	e(s) and manner as stated.
	he Hos in 24 hc he Fun pletely	ledical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc and manner stated.	curred at the time, date	and place, and due to the cause(s)
	with To t	Σ	29b. Signature and title of certifier 29c. License number D 3 i 4 6 4	29d.	Date signed (Month, Day, Year) C () 4 D C
	6		To a series of the series of death (from 23a) Trupo Bright	to 3 not	BALTIMORE MUZIZIO
	Sta		31. Date filed (Month, Day, Year) 32. Regionar's Signature	mu Jry	
L	Regist	rar	JUL 0 5 2006 Miner St. Speeds		

06-04667 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Frank C. Tompson 2006 20937 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Month Day July 3, 2006 1436 hrs Medical Examiner 4b City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 3 Western Winds Circle Windsor Mill **Baltimore County** 5 Social Security Number 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State of **Funeral** Days Hours Director 213-64-4071 5 Country) 2 Usual Residence of Decedent 10d Inside City Limits 1 Yes 2 X No or items 23a or 28a-f show Wind so es 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene Director 10g. Citizen of What Country 10e Street and Number Nestern Funeral Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No Race - American Indian, Black, item 27 is marked other than "natural", or items traumatic event, the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Never Married 2 Married Yes 4 Nivorced If Yes, Give Year Specify Black Widowed 1 Yes 2 X No specify ģ or Date 16a Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Ю exu1001 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be James 19a Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 21201 ranz Fran lhom Uson 20a. Method of Disposition 20b Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 2000 Donation 5 Other Specify 22 Name and Address of 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or Approximate Interval Physician /Medical Between Onset and Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last and Physician/Medical ding physician a AMENDED UNPENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Fatty liver Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes 26. Place of Death (Check only one) 25 Was case referred to medical Be Other_A Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other. Scene 1 🗸 Yes 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d Describe how injury occurred Certification: 1 🗸 Naturai 1 Yes 2 No Pending To the Funeral Director: Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

10

State

Registrar

30 Name and address of person who completed cause of death (Item 23a) Ana Rubio MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

2006

ELEGEAR.

O.C.M E.

111 Penn Street, Baltimore, MD 21201

July 4, 2006

06-04081 Osa A. Tannis

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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Physician/	Decedent's Name (First, Middle,Last)	2. Date of Deat Month	Day Year 0740 has
edical Examiner	4a. Facility Name (if not institution, give street and number)	June 14, 2 4b. City, Town, or Location of Death	4c. County of Death
	Baltimore Washington Medical Center	Glen Burnie	Anne Arundel
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs last birtho	day) If Under 1 Year If Under 24Hrs. 8. Date of Birt	th(MM/DD/YYYY) 9. Birthplace (State or Foreign St. Reent
Director	113-80-12902 1×1 20 = 30	Yrs. Months Days Hours Min. //-20	-1975 Country) W. I.
8	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	r Location	10d. Inside City Limits
ow an	10d. State 10d. County 10d. City, 10wind	5 12 1 1 2	1 Ves 2 No
ryland ta-f sh it once	10e. Street and Number	2 10f. Zip Code 10	Og Citizen of What Country?
with the Maryland ns 23a or 28a-f show any be notified at once. sral Director	3701 Teatwood Drive	21208	U.S.A.
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. This marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	- 14, Race - American Indian, Black, White, etc.
or items 23	1 Yes 2 No		Thek
2 hours afte "natural", Examiner	3 Widowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. D	1 Yes 2 No specify: ecedent's Usual Occupation (Give kind of work done	Specify: D GC K 16b. Kind of Business/Industry
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exar	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use retired)	h / .
15-0036 filed within 72 1 Hygiene. ed other than t, the Medical	12 4	Leacher	Education
21215-0036 uld be filed within 72 Mental Hygiene. marked other than r event, the Medical o Be Comple	17. Father's Name (First, Middle, Last)	18 Mother's Name (First, Middle, M	Valden Surname)
D 21215-003 should be filed within and Mental Hygiene. 7 is marked other th natic event, the Med To Be Comp	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number of Rural Route Num	beer (City or Town, State, Zip Code)
e, MD 2 I and 2 shou Health and I item 27 is r r traumatic	Tracy Ann Tennis 3	701 Rakwood Dr. 7	Kestille, Nd. 21208
2 - E E 5	1 X Burial 2 Cremation 3 Removal from State cremator	Disposition (Name of cemetery, Date ry or other place)	20c. Location'- City or Town, State
Baltimore, permit. Pages I ar Department of He Department of He Important: If ite injury or other tr	4 Donation 5 Other Specify:	ico (em 6-23-2006	Valhalla, New York
Baltimo permit. Page: Department o Important: I	21. Signature of Funeral Service Licensee	22 Name and Address of Facility oug 1855	about 1 service P.A.
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not		est, shock, or heart Approximate Interval Between Onset and
/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Cardiac arrythmia		Death
	or condition resulting in death) Due to (or as a consequence of):		
Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
ed nsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of).		
cuted and transit	Q.	- M. OF 7 7 /C (OC 1111)	
ian exe	MUNPENDED AMENDED Item#23a,27,	perME,g857,7/6/06 TT	
8760, ificate be ng physic is the bur	IF FEMALE: 23b. Was decedent pregnant in the 22c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
Box 687 e death certifing the attending ed for use as t	past 12 months? 4 Pregnant at time of death 5	Other (Specify)	
D. Bc the dea by the a	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I 23e. Did to	obacco use contribute to the cause of death?
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the ras after death. al Director: After this certificate has been signed by 1 led in by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached in by the funeral director.		1 Yes	s 2 No 3 Probably 4 V Unknown
Records, The law requires ficate has been sig page 2 should be Completed		24a. Was autor	
Reco The law icate has page 2 g		perfo 1 ✓ Yes	rmed? death? 2 No 1 Yes 2 No
Vital Rechysician: The this certificate didirector, page	25. Was case referred to medical	26 Place of Death (Check only one)	
F Vite	1 Yes 2 No Inpatient 2 ER/Ou		Residence 6 Other. how injury occurred
n of viding Phy. H. After the funeral		1 Yes 2 No	now injury occurred
Division (Division (2 Accident Investigation 3 Suicide 6 Could not be		Street and Number or Rural Route Number, City
Divi	3 Suicide 6 Could not be determined (Specify)	or Town, S	State)
8 > -	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ith occurred at the time, date and place, and due to the caus ovestigation, in my opinion, death occurred at the time, date	
To the H within 24 To the Fi completed	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	29c. License number	29d Date signed (Month, Day, Year)
-	Qual	O.C.M.E.	June 15, 2006
	30. Name and address of person who completed cause of death (Item 23a)		
		Penn Street, Baltimore, MD 21201	
Stat Registra		Specific	
DHMH 17 Rev 1/2001	10 TOOO 12000	IGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🖺 🖺 🔓 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July **Physician** аМ 2006 1:45 Margaret Bernice Tabor /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Catonsville Baltimore Frederick Villa Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/10/1924 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours Min. *Country)* Virginia 1 ☐ M 2 🗓 F 82 Yrs. 225-30-7843 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show r Items 23s or 28s-f shoulder nust be notified at 1 XYes 2 No n/a Baltimore Director 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 21223 United States 506 Hurley Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 🖸 No Specify: Specify: White δ r than "natural", o 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 is marked other than ury or other traumatic event, Item Real Estate Agent Self Employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Theodore Mathison Hogston Betty Mary Doane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1322 Meadowvale Rd Glen Burnie Maryland, 21060 Nina R. White / sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Good Shepherd Cemetery 7/6/2006 Ellicott City, Maryland 4 □ Donation 5 □ Oper (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral S roice Licens 1328 Sulphur Spring Rd Arbutus, Maryland 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition RENAL FAILURE Pnysician /Medical resulting in death) Due to (or as a consequence of): Examiner YWEEKS EHYDATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ALZHEIMEN'S DEMENTIA or Attending Physicien: The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit STAGE END Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9□ Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 2 No 1 ☐ Yes 21 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 1 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 200 No 2 ER/Outpatient 3□ DOA After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospitel or Attendir within 24 hours after death. To the Funeral Director: All completely filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

DHMH 17 Rev 1/2001

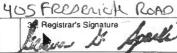
State Registrar

31. Date filed (Month, Day, Year)

LOULTON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



ORIGINAL

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1)0040012

SOITE 204, CATONSVILLE, MD

29d. Date signed (Month, Day, Year)

2006

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
1	Pn /I Ex
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed

1:48 p.m.

JUNE 26, 2006

ALVERTA TAWNEY

	1 - State Registrar		2.3.00	·······································	Ce	tifica	te of De	eath	. 140		Reg. No.	200	6 209	
an	Decedent's Name (First, M.	,	atheri	ine Alv	erta T	awney	7			2. Date of Dea Month June	Day	Year 2006	3. Time of Dea 1:48 P	
cal	4a. Facility Name (If not instit	-			:		Town, or Lo		Death	bune		County of De	ath imore Co.	
	5. Social Security Number 215-18-9008	6. Sex	м 27∏ г	7. Age (In yrs. 84	last birthday) Yrs.	If Unde Months		f Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day Jan . 2	, Year)		irthplace (State or Fo Country) Maryland	
	Usual Residence of Deceden 10a. State 10b. Con			10c. Ci	ty, Town or Lo	cation					10d. Inside C			
Director	Maryland	Balt	imore			Middle River						10g. Citizen of What Country?		
1	10e. Street and Number 1212 Stump	f Ro a d				10f. Zi	p Code	212	20			ted Si		
by Funeral	11. Marital Status 1 Never Married 2	Married	Armed For 1 ☐ Yes If Yes, Giv	25 No		Was Dece f Yes, spe	cify Cuban,	anic Origi Mexican, Specity:	in? (Spec Puerto F	cify Yes or No- Rican, etc.)		4. Race - An Black, Wh Specify:	nerican Indian, lite, etc. White	
	35 Widowed 4 □ Divor 15. Dece (Specify only hi	dent's Educ	Year or Da ation completed)	ates:	(Give	kind of wo	al Occupation	on	of workin	g		d of Busines		
Completed	Elementary/Secondary (0-	12)	College (1	-4or 5+)			se retired) achine	0p e :	rato	r	Clc	thing	Manufactu	
To Be (17. Father's Name (First, Mid Frank Adel						18			(First, Middle. Smith	Maiden :	Su <i>ma</i> me)		
-	19a. Informant's Name/Relat	ionship (Typ						d Number	or Rural	Route Numbe				
	Martha Flowe	rs Rie	s (Dau	20b. I	Place of Dispo	sition (Na	me of	oad		dle Riv			and 21220	
	M⊠Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Othe		moval from S	State	cemetery, crer 11y Hi	-		ns.	6/29	/2006			River, MD	
	21. Signature of Funeral Sen	vice License	7]					me of D			nc. 21222	
dical Examiner	d													
hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23	1 Live bi	come of pregnation 2 Feta ant at time of co	al death 3	Ectopic p Other (sp					2:	3d. Date of de Month	elivery Day Year	
by P	Part II. Other significant con	ditions conti	ributing to de	eath but not res	sulting in the u	nderlying o	ause given i	n Part I.			bacco us		to the cause of death	
Completed										24a. Was a autops perform	sy	24b. Were a prior to death?		
o Be	25. Was case referred to med examiner? 1 ☐ Yes 2 X No	_	spital:	npatient 2	ER/Outpatien	1 3□ D0	T Out			Check only on	-	X ∩ther (Sn	ecify) HOSPIC	
cation: T	27. Manner of Death 1 Natural 5 Pe 2 Accident inv	nding estigation		of Injury h, Day Year)	28b. Time of Injury		28c. Injury at Work?		28	3d. Describe he			ocity) HODI IO	
riffe		uld not be termined	28e. Place buildin	of Injury - At h	ome, farm, str fy)	eet, factor	y, office		28	Bf. Location (Si City or Town	reet and n, State)	Number or F	Rural Route Number,	
Ö										nd due to the cad at the time, d	ause(s) a ate and p	and manner a place, and du	s stated. e to the cause(s)	
dical C	(creek only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.									- 2	9d Date			
dical C	29b. Signature and title of ser	tifier			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								ith, Day, Year)	
edical C	29b. Signature and title of persons of perso	0_	inleted cause	e of death /ltos	n 23a) /Tuno	Print\	D43	725				_	•	

		•	For State Registrar		Otate of Wi	arytari		tificate of	lealth and N Death		Reg. No.	2000	6-	094
	Physicia	20	1. Decedent's Name (Fir		*					2. Date of D Month	Day	Year		e ol Death
	Physicia /Medic		Kermi				•			June		2006		1:30a ^M
	Examin	er	4a. Facility Name (If not	_				Leonard	or Location of Death	1		County of Death . Mary		
			St. Mary's 5. Social Security Number			ie (In vrs.	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth	9. Birth	place (Sta	te or Foreign
	Funeral Director		212-32-5253 Usual Residence of Dec	1	Ž ^{M 2□ F} 70		Yrs.	Months Days	Hours Min.	Sept 1	ay, Year)	Cou	intry)	
	land ow			. County		10c. City	y, Town or Lo	cation					10d. Inside	e City Limits
	Mary Indi	ţ	MD	Carroll		Sy	kesvil	lle					1 🗆 ነ	res 2 ∏No
	r 28	lrec	10e. Street and Number					10f. Zip Code			_	zen of What Cou	ntry?	
	th wit	a	511 Tangle	wood Dr	ive			21784			USA			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 ie marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be nutified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 🛣		12. Was Decedent Armed Forces? 1 M Yes 2 ☐ If Yes, Give Year or Dates:)	tham	Was Decedent of Inf Yes, specify Cub 1 ☐ Yes 2 🏋 No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or N Rican, etc.)		14. Race - Ameri Black, White Specify: Whi	etc.	1,
2-0	72 ho natur lical	eted		Decedent's Ed			16a. Dece	dent's Usual Occup	pation during most of wor	king	16b. Kii	nd of Business/Ir	ndustry	
21	ithin 7	Completed	Elementary/Secondar		College (1-4or	5+)			during most of wor		IT C	Air Fo	~~~	
2	led w tygier her th	ខ	17. Father's Name (First	Middle (act)	+2		116	aster Sar	18. Mother's Nan	ne (First Middl			rce	
/lanc	uid be fi Mental H arked ot	To Be	Kermit Ar		_					a B. Go		,		
Baltimore, Maryland 21215-0036	alth and 27 ie ma		19a. Informant's Name/ Janice Gri				511	Canglewoo	od Dr., S				p Code)	
nore,	ages 1 a int of He t: if item y or othe		20a. Method of Dispositi 1 ☐ Burial 2 🛣 Cr 4 ☐ Donation 5 ☐	emation 3 🗆	Removal from State			sition (Name of matory or other pla tv Cremat	cion 7-5-0	Date)6		esville,		9
3altir	ernit. P Separtme mportan iny injur		21. Signature of Funera	I Service Licen	see	+	22	2. Name and Addr	ess of Facility Ha	ight Fu	neral	Home &		el .
	40240		23a. Part1. Enter the di			d the deat			95 Sykes			. 704	Approxi	mate Between
8760, G	Physician /Medical Examiner bhysician and bhysician and the prijal-transit transit.	dical Examiner	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition if any, leading to immediate, such cause. Enter Undertyin Cause (Disease or injurthat initiated events resulting in death) Last		b. Chron Due to (or as	a conseq	uence of):	nmatos	y dem	ye lina	ling	Polym	ן סרו	ath ₁
P.O. Box 6	The law requires that the death certific sie has been signed by the ettending p bage 2 should be detached for use as i	by Physician/Mec	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 □ Yes 2 □ No 9 □ Unknown	iths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3[Ectopic pregnand Other (specify)	Sy .	Wis Torr	1	23d. Date of deliv Month	very Day	Year
s,	uires that t signed by d be detac		Part II. Other significan	t conditions	ontributing to death	but not res	ulting in the u	nderlying cause g	ven in Part I.			use contribute to		of death?
Division of Vital Record	The law requirete has been page 2 should	Completed								24a. Wa aut per 1 🗆 Yes	opsy formed?	death?	opsy findir ompletion 2 No	ngs available of cause of
ita	sician: Th certificate irector, pag	Be	25. Was case referred examiner?	to medical					26. Place of Dea	ath (Check only	one)			
>	w 70	70	1 ☐ Yes 2 X No		Hospital: 1 XInpat	ient 2 🗆	ER/Outpatie	II JU DOA		lome 5 Re	sidence (6 □Other (Spec	ify)	
Ē	ding Ph. h. After thi funeral		27. Manner of Death 1 Matural 5	☐ Pending	28a. Date of Inj (Month, D	ury a <i>y</i> Yea <i>r)</i>	28b. Time o Injury	Wo		28d. Describe	how injur	y occurred		
Divisio	Atten or deal ector: by the	Certification:	2 Accident 3 Suicide 6 4 Homicide	Could not b determined	e One Place of Ir	njury - At h tc. (Speci	ome, farm, st	M 1 [Yes 2 No		(Street an own, State	d Number or Rui)	ral Route f	Number,
	Hospita 4 hours Funere ely fille	edicai C			nysicien: To the bes niner: On the basis and manner s	of examina								se(s)
	To the Mithin 2. To the I complet	Me	29b. Signature and title		shah	· · · · · ·		29c. Licen	H706	6		te signed (Month		
	· V		30. Name and address	ol person who	completed cause of	death (Iter	п 23а) (Туре	Print)				,		
	3		Dr. Avani						onardtown	MD 20	0650			
	Sta Regist	ate rar	31 Date filed (Month /	Day Voorl	2006 32. Regi	trar's Sign:	ature			.,				
D1	HMH 17 Pev 1/2	-		JE 00		To be	100							

DHMH 17 Rev 1/2001

			For State Registrar	State of	Marylar		artmer				ental Hy	/giene	L. U	0.6	2091	+2
			1. Decedent's Name (First, Middle, L	ast)							2. Date of Do	eath Da	v ,	rear	3. Time of Death	
	Physicia /Medic		RU	rh I	J. V	<i>I</i> ETTERS	3				07	0		26	3:52an	M M
	Examin		4a. Facility Name (If not institution, gi	ve street and num	ber)		-		Location				County o			
			Franklin Square	Hospita	1 Cent	er			dale)			Balti	mo	re	
	Funeral			Sex 1□M 2MF	. Age (In yrs.		Months Months	r 1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D July 1	irth ay, Year)	0/2	9. Birthp	place (State or Fore	ign
	Director		214 40 0000		62	7 115.					July 1	8, 1	943	Ma	rÿ1and	
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. C	ty, Town or L	ocation							1	Od. Inside City Lim	its
	l sho	ō	Delaware Sussex	County		Selbyv	7i11e								1 Yes 2 1	No
	the h	Director	10e. Street and Number			DCID		p Code				10g. Ci	izen of WI	nat Cour	ntry?	
	with a or	₫	30 Berue Court					19975				U	.S.A.			
	urs after death with the Marylan el', or Iteme 23a or 28a-f show Exarter cust be notified at	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	J.S. 13.	1			igin? (Spe	cify Yes or N Rican, etc.)	0-			can Indian,	
10	fler o	필	1 ☐ Never Married 2 Married	Armed For 1 ☐ Yes	2 No						Rican, etc.)		Specify:	White,	etc. to	
036	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	e tes:		1 🗆 Yes	2 ☑ No	Specify	:			Specify:	*****		
9-0	72 hours af	ted	15. Decedent's (Specify only highest g	Education		(Give	edent's Usi	ork done d	durina mo:	st of workir	19	16b. K	ind of Bus	iness/In	dustry	
213	en e	npie	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT	ise retired	1)		-		1 C T			
12	filed within 72 hours after death with the Maryland Hygiene. ither then "naturel", or Iteme 23a or 28a-f show ent, the Medical Examination with the multified at	Be Completed	12	0		Ha	airdr	esser			/P**		elf-I	-	oyed	
S P	be fill doth	Be	17. Father's Name (First, Middle, Las	•	-				18. Moth		(First, Middle)		
× a	ould Men Marke	ဥ	Francis		tlove	40. 44.5		(2)		Leov		owle		· · · · · · · · · · · · · · · · · · ·		
<u>a</u> (⊰	2 sh and Is m		19a. Informant's Name/Relationship				-				≀Route Numl 'ille,					
Wetters, Ruth Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other then "ni eny injury or other traumatic event, the Mediance.		Donald Wetters 20a Method of Disposition	Sr.	20h						ate,	-	ocation - C			
	ges 1 t of F if ite or ot		1 Burial 2 Cremation 3		Mare 1	Place of Disp cemetery, cre				07/06				•		
% E	Pa tmen tant:		4 □Donation 5 □ Other (Spec	THE RESERVE OF THE PARTY OF THE	Ne	y Cath			1.			baı	TIMOI	e,	Maryland	_
3al	permit Depar Impor Impor ony in		21. Signature of Funeral Service Lic	35"	11/		22. Name a McC111				neral	Home	PA			
	40364		23a. Part1. Enter the disease, or co	aun	//					-			, Mai	ryla	nd 21230 Approximate	
			shock, or heart failure. List on	y one cause on ea	ach line.				g, 5001. a.	3 04: 3:20 0	. roopiiatory	u., 001,			Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Sma	1 cell	lung co	unce	r						_	6 month	S
	Examiner		1	Due to (or as a conse	quence or):	+ 1									
		Je.	Sequentially list conditions,		Sive h		TUSI:	5	_		_					
28	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				17									
MO	al-tra	xar	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):								_		
, 260	ate be executed nysicien and he burial-transit	calE														
687	ficate p physis the		_	7-												
Box	certi nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out								1	23d. Date	of deliv	ery	
ă	death e ette	Cia	in the past 12 months? 1 ☐ Yes 2 ☒ No	4□Pregna	rth 2 ☐ Fet ant at time of		□Ectopic □ Other (s		·				Mon	th	Day Year	
O.	the cy the acher	hys	9 □Unknown	9□ Unkno	wn											
	Physician: The law requires that the death certifica this certificate has been signed by the ettending ph ral director, page 2 should be detached for use as th	by P	Part II. Other significant conditions	contributing to de	ath but not re	sulting in the	underlying	cause giv	en in Part	l.	23e. Did	tobacco	use contri	oute to t	he cause of death?	1
Ę	w require been sig should b				<u>-</u>						1)🛚	Yes 2	□No :	3 🗌 Prot	oably 4 □Unkno	wn
ဝိ	aw requ s been 2 shoul	plet									24a. Wa	s an	24b. W	ere auto	ppsy findings availa	ble
Ä	The lav	Completed										formed?	de	eath?	2 N O	٠.
<u>ita</u>	ding Physician: The In. After this certificate he funeral director, page	BeC	25. Was case referred to medical						26. Plac	e of Death	(Check only					
>	ysici ils ce direc	To	examiner? 1 ☐ Yes 2 DXNo	Hospital:	npatient 2	ER/Outpatie	ent 3 🗆 🗅	OA Oth	er: 4 □ N	lursing Hor	me 5□Res	sidence	6 □Othe	(Speci	fy)	
0	ng Phr ter thi	Ë	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of (Mont)	of Injury h, Day Year)	28b. Time Injury	of	28c. Injur Wor	y at k?	2	28d. Describe	how in t	ry occurre	d		
<u>.</u>	tendir seath. tor: Af the fu	atic	2 ☐ Accident investigat	ion			М	1 🗆	Yes 2]No						
Division of Vital Records, P.O.	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28 e. Place	of Injury - At ng, etc. (Spec	home, farm, s tify)	street, facto	ry, office		1	28f. Location City or To	(Street a own, Stat	nd Numbe e)	r or Aur	al Route Number,	
Ω	ital o irs aft ral D lled ir			1												
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical		Physician: To the aminer: On the ba and mann	sis of examir											
-	To the within 2 To the complet	Me	29b. Signature and title of certifier	1			2	c. Licens	e number			29d. Da	ıte signed	(Month,	Day, Year)	
	F > F 0		I WARCE	AND			•	DØ	6634	154		Ju	141.	20	06	
	$\overline{\Omega}$			o completed caus		em 23a) (Type							1.			
	10		11 (10)			Way, 1	Ellius	- Cut	y M	> 2	1043					
		ate	31. Date filed (Month, Day, Year) JUL 0 5 20		egistrar's Sigr	nature	. des .		•							
	Regist	CIL	10 L U 0 LU	UU KARA	102 2 6	13000	BARY In									

DHMH 17 Rev 1/2001

06-04	549
Anita	Wesley

Please Type or Print in Black Indelible Ink

Wesley		- For State	State o	of Maryland /		tment of I ficate of L	Health and Ment Death		g. No 2 (106 209
Physicia cal Exami	n/	e gistrar I. Decedent's Name (F	-irst, Middle,Last)		Carol	Wes1	. y	2. Date of Death Month June 29, 2	Dav Year	3. Time of Death 0742 hrs
Jai Exaiiii		1a Facility Name (if no	ot institution, give			4b	City, Town, or Location of		4c County of Dea	ath
		Maryland Gen					Baltimore	an la p	hannan and a r	Death when a Charles
Funeral Director		5. Social Security Num 212-56-35	11 1	7. Age	(In yrs. last	t birthday) Yrs.	If Under 1 Year If Under Months Days Hours		h(MM/DD/YYYY) 9. E Ford	eign Country) N . C .
v any	ļ	Usual Residence of De 10a. State 10	ecedent b. County		•	own or Location				10d Inside City Limits 1 Yes 2 X No
Aaryland 28a-f show 1 at once.	ğ	Md 10e. Street and Number	Balto)	Cato	nsville	10f Zip Code	110	og. Citizen of What Co	
he Mary r or 28a ified at	Director		Bluff Ct	:			21228		USA	,
Jale 19-10-00-00 Mental Hygiene Mental Hygiene marked other than "natural", or items 23a or 28a-f she ic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status	2 Married	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was	Decedent of Hispanic Orig , specify Cuban, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Am White, etc	erican Indian, 8lack,
ter dear ", or it er mus		3 XWidowed	4 Divorced	1 Yes 27 If Yes, Give Year	∑ No	1 7	es 2 X No specify:		Specify	Black
ours af	d b	15. Decedent's Educ		or Dates:	pleted) 1		Usual Occupation (Give t of working life, DO NOT		16b. Kind of Busines	· ·
n 72 hc an "na ical Ex	Completed	Elementary/Second		College (1-4 or 5			Counselor	400 (011104)	State o	f Maryland
iled within 72 h Hygiene I other than "1 the Medical E	E .	12th g		2 years	-	Touch		's Name (First, Middle, N	Maiden Surname)	
tal Hy ked of	Be C	James Doug					Agne	s Gray		
2 should be filed within and Mental Hygiene. 27 is marked other the matic event, the Med		19a. Informant's Name Agnes Doug				_	Address (Street and Num			
' P # # #	}	20a Method of Dispos	sition	-			on (Name of cemetery	Date	20c. Location - City	or Town, State
ages I and 2 should ent of Health and M nt: If item 27 is m r other traumatic e		1 X Buriat 2	Other Specify:	Removal from Sta		ematory or other	rial Park	7-3-2006	Randalls	town, Md
permit. Pages I an Department of Hea Important: If ite		21. Signature of Fune	ral Service Licens			22. Na	me and Address of Facility	y March Wes	st F/H	
		Manyo	NO	Stand	m)	4300 W mode of dying, such as c	labash Avenu	ie Balto,	Md 21215 Approximate Interval
hysician /Medical		23a Part I. Enter the tailure. List only	one cause on ear	ch line.		Jo not enter the	mode of dying, such as c	ardiac of respiratory and	ost, shook, or hour	Between Onset and Death
Examiner		Immediate Cause (Fir or condition resulting		Bowel Ische Due to (or as a conse		:				
		Sequentially list cond	ditions, b.	Superior M			e Rupture			
	iner	if any, leading to imm cause Enter Underly	ying Cause	Oue to (or as a conse	equence of):					
d sit	Examiner	(Disease or injury that events resulting in de	at initiated	Due to (or as a conse	equence of):	:			=	
certificate be executed nding physician and see as the burial - transit	AMENDED item#23a-b,PII,27,perME,C857,7/10/06 TT IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									
60, ate be physici he buri	Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery								,
6876 certifica nding ph	ian/	23b Was decedent pr past 12 months?		1 Live birth Pregnant at	time of dea	=	al death 3Ectopi er (Specify)	c pregnancy	Month	Day Year
BOX BO/D Le death certificat the attending ph hed for use as the	ıysic	1 Yes 2 No		9 Unknown		3 O(i)				
that the red by the detached	by Pr						iderlying cause given in Pa			to the cause of death? Probably 4 Unknown
uires that n signed b Id be deta	ed b			ovascular di	sease,	human in	munodeficiency	24a Was		autopsy findings available
aw requires been 2 should	Completed	viral ir	nfection					autop		to completion of cause of
certificate bector, page	Con						00.00	1 ✓ Yes	2 No 1 🗸	Yes 2 No
vican. The law requires that the this certificate has been signed by I director, page 2 should be detach	Be	25. Was case referre examiner?		fospital: 1 🗸 Inpatie	ent 2 1	ER/Outpatient	26 Place of Death	Nursing Home 5	Residence 6 0	ther
Of VI ing Physi After this uneral dir	. To	1 Yes 2 27. Manner of Death	INO	28a Date of Inju	JIV I	28b Time of In		k? 28d Describe	how injury occurred	
ending Phy ath or: After th	tion		5 Pending Investigate		real)		1 Yes 2	No		
pital or Attendi ours after death eral Director: /	Certification:	2 Accident 3 Suicide	6 Could not determine	be 28e. Place of Ir	njury - At ho	me, farm, stree	, factory, office building, e	etc. 28f Location (or Town, \$		Rural Route Number, City
Hospi 24 hou Funer ely fil		4 Homicide 29a Certifier 1 C	Certifying Physic	ian: To the best of m	ny knowledg	e, death occurr	ed at the time, date and plon, in my opinion, death o	lace, and due to the cau	se(s) and manner as s	started.
To the within 2 To the complete	Medical	- 6.0		r: On the basis of exa and manner stated	ummation an	iu/or investigati	29c. License number		29d Date signed (
	Σ	29b Signature and ti	a a O	100	0~	f .	O.C.M.E.		June 29, 2006	•
}		30 Name and addres	LOC (completed cause of	death (Item	23a)				
		Pamela Sout		ssistant Medica			enn Street, Baltimo	re, MD 21201		
Ş	tate	31. Date filed (Month	n, Day, Year)	32 Registra	ar's Signatui	re	••			
Regi			0 5 200	6 Been	, K	Dogu	U			
	strar	· ·	i, Day, Year)	32 Registra	ar's Signatui	ORIGINA	4			

		•	For State Registrar	State of Maryla	· ·	ent of Health and leate of Death	Mental Hygiei	2000	20941
	Dissolution		1. Decedent's Name (First, Middle, Last)		* *		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Larlen	ν ω	illiam	S	June .	29 206	1:10 PM
	Examin	er	4a. Facility Name (If not institution, give s	treet and number)	4b. 0	City, Town, or Location of Deat	h	4c. County of Death	timere
	Funeral		5. Social Security Number 6. Sex	7. Age (In yr		nder 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		lace (State or Foreign try)
	Director		110-10-6265	M 2XF 5	Yrs. Mon	ths Days Hours Min.	April 28,	956 Ma	ryland
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Location		/	1	Od. Inside City Limits
	Mary B-f sh	tor	md. Batt	emore	K	in dalls	-town		1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Number	to Sodal	e Cof 10f	2/133	10g.	Citizen of What Coun	try?
	eath v	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13. Was D	ecedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Americ	
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hyglene. If item 27 is marked other than "natural", or iteme 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 Yes 2 No /9 If Yes, Give Year or Dates: Z	76-	specify Cuban, Mexican, Puen s 2 No Specify:	o Rican, etc.)	Black, White,	lack
	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's (Give kind o	f work done during most of wo	rking 16b	. Kind of Business/Inc	dustry C.T.
2121	within ene. than "	Juno	Elementary/Secondary (0-12)	College (1-4or 5+)	Λ	Tuse retired).		Public	works
	illed other	BeC	17. Father's Name (First, Middle, Last)	a ya			ne (First, Middle, Maid	den Sumame)	
Maryland	Mental arked o	ToE	William H. Ste	venson		Haze	1 4. 1	Jay	
Mar	12 sho h and 7 is mu traum		19a. Informant's Name/Relationship (Ty)	oe, Print) - daustite	_	ress (Street and Number or Ri			
	Health tem 27 other tr		20a. Method of Disposition	20b	Place of Disposition cemetery, crematory	(Name of		Location - City or To	
E	Pages nent of int: if it		1 Deurial 2 Deremation 3 □R 4 □ Donation 5 □ Other (Specify)	emoval from State	contactory, crantactry		7-06 01	vinjo n	iLLS, MD.
Baltimore	permit. Pag Department Important: i any injury o once.		21. Signature Duneral Service License	//	22. Nam	e and Address of Facility	70 Freahil	LTON Pas	S
	40 E € 0		23a. Part. Enter the disease, or compli	cations that caused the de	eth. Do not enter the		neval Hane	Bacto, m	d.21229 Approximate
1	Pnysician /Medical Examiner		shock, or heard failure. List only on Immediate Cause (Final disease or orndition resulting in death)	Due to (or as a conso	AST C	AnceR			Interval Between Ons t and Death
8760,	eath certificate be executed attending physicien and for use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to mmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons					
9	certificate nding phys use as the	ledic							
O. Box	0 0	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3 Ectop	ic pregnancy r (specify)	1225	23d. Date of delive Month	ry Day Year
rds, P.O.	The law requires that the de ate hes been signed by the a bage 2 should be detached t	ē	Part II. Other significant conditions con	tributing to death but not re	esulting in the underlyi	ng cause given in Part I.	23e. Did tobacc	co use contribute to th	e cause of death? ably 4 □Unknown
S	aw requir ss been si 2 should 1	Completed					24a. Was an autopsy	24b. Were auto	osy findings available inpletion of cause of
<u> </u>		Com					performed	death?	2 No
Vita	Physicien: The law this certificate hes b ral director, page 2 s	Be	25. Was case referred to medical examiner?	ospital:		1 04	ath (Check only one)		Itani
on of	ding Phys	lon: To	1 Yes 2 No 27. Mannar of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Injury at Work? 1 Yes 2 No	lome 5 Residence 28d. Describe how in		Hospice
Division of Vital Records,	i or Atten after deat Director: d in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, fa-	Section 1	28f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my k nar: On the basis of exami and manner stated.	nowledge, death occur nation and/or investiga	rred at the time, date and place tion, in my opinion, death occu	e, and due to the cause arred at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	1.0	2	29c. License number	29d.	Date signed (Month,	Day, Year)
	0 14	1	Ill Hother	my Kelly	, my	nangon	Ju	ned9,0	1006
	10+1	1	W. A. Riley	GBMC 6		D25205 harles St.	Balto N	nd 212	05
	Sta Registi		31. Date filed (Month, Day, Year) JUL 0 5 200	32 Segistrar's Sig	Is Speak				

Williams, Darlene 0/25/06 1 pm

				1 - For State Registrar	State of M	1aryla			nt of H	ealth and I Death		giene Reg. No.	006	20945
				Decedent's Name (First, Middle	e, Last)						2. Date of Dea	ath	Year	3. Time of Death
		Physici /Medic		Helen Anna	Wesolowski						DULY	Day 2	2006	1915 PM
		Examir		4a. Facility Name (If not institution	1.4	7)		4b. City		Location of Death	1		nty of Death	
		*	N	5. Social Security Number			land himbuland	'SA	LTI/ er 1 Year	NORE If Under 24 Hrs.	0 Data of Bird	BAL	TIMON	ef CITY
		Funeral Director		219-01-2742	1 M 2 X F	89	. last birthday) Yrs.	Months		Hours Min.	8. Date of Birt (Month, Date July 27	Year) 1916	Cour	olace (State or Foreign ortry) aryland
				Usuel Residence of Decedent							July 21	, 1710	1410	otycana
		nylan show	_	10a. State 10b. County		10c. C	ity, Town or Lo						1	10d. Inside City Limits
		8a-f	Director		/A				Balti	more				1 X Yes 2 □ No
		with th	2	10e. Street and Number	-014			10f. Z	ip Code	01012		10g. Citizen o		,
		eath	by Funeral	3324 Chesterfi	12. Was Deceden	t Ever in	U.S. 13	Was Dec	edent of H	21213	pecify Yes or No-	14 R	U. S.	
	(0	r then	Fun	1 X Never Married 2 ☐ Marr	Armed Forces	?				spanic Origin? (Si n, Mexican, Puerti	o Rican, etc.)	В	lack, White,	
	03	rai', o	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dates			1 ∐ Yes	2X No	Specify:		Spec	city:	1hite
	5-0	filed within 72 hours after death with the Maryland Hygiene. After then "natural", or items 23a or 28s-f show ther then "natural", or items rout be retified at out, if a Medical Exaciline rout be retified at	Completed	15. Deceden (Specify only highes	t's Education st grade completed)		16a. Dece	kind of w	rork done d	furing most of wor.	king	16b. Kind of	Business/In	dustry
	121	within	mp	Elementary/Secondary (0-12)	College (1-4o	5+)	life.		use retired			Mont	Danhi	us Company
	d 2	Hygie ther ant,	CO	12th Grade 17. Father's Name (First, Middle,	Last)			_ 30	creto	18. Mother's Nan	ne (First, Middle,			ng Company
	lan	should be and Mental I is marked o umatic sve	To Be	John Wesolows	bi					Bal	bina Ru	zulo		
	Maryland 21215-0036	2 should be filed within 72 hours and Mental Hygiene. is marked other then "natural; reumatic svent, if a Medical Exa	-	19a. Informant's Name/Relations			19b. Mailir	ng Addres	ss (Street a	and Number or Ru			m, State, Zip	Code)
		permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Itema 23a or 28a-f show my injury or other traumatic svent, the Medical Exercitment and Le notified at ance.		Stanley A. Wesc	rlowski (Bro						., Balt	imore,	Maryl	and 21213
	3altimore,	Pages 1 nent of He nt: if iter iry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from State	20b.	Place of Dispo cemetery, crer	sition (Na matory or	ame of other plac	θ)	Date	20c. Location	n · City or To	own, State
	Ë	. Pag tment tant: jury o		4 Donation 5 DOther (S	pecify)	St	t. Stan							Maryland
	Bai	Departiment Departiment Important Information Informat		21. Signature of Funeral Service	Licensee					s of Facility Sc				
			_	23a. Part1. Enter the disease, or	complications that cause	ad the dea				s Lane,			iykana	Z I Z I Z I
		0.5		shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.	C.			9, 00011 00 00.0.0	or rospiratory ar	, ,		Interval Between Onset and Death
	10	Physician /Medical		disease or condition resulting in death)	a Due to (or a	PT1		TOCK					-	
X	78	Examiner			· Uzi	NAR	v TA	Act	IL	ESTEIN	N			
3		BIL =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a cuilse	quепсе от).							
\tilde{Z}		n and ial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a		TIVE	HE.	ART	FAILUR	E			
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3	687	physicate physicate	edicai		d	KE)	CLERO	iJ C	_ Ca	CON TIME	TRIERY	DISENS	C	2014
	Вох (Attending Physician: The law requires that the death certific reath. r death. sctor: Atter this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			-				23d. C	Date of delive	∍rv
>	œ.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 🗷 No	1 ☐ Live birth			JEctopic Other (s	pregnancy s <i>pecify)</i>				Month	Day Year
al,	0.	at the d by the	hys	9 Unknown	9□ Unknown									
-TI	Ś	signed d	by	Part II. Other significant condition	ons contributing to death	but not re	sulting in the u	nderlying //						ne cause of death?
	ord	w require been si should	ted	TIRIAL IIX	KI LA FJON	- 1 -	314143	132	7 (EREBRAL	1 L Y	′es 2□No		pably 4 Munknown
	ec.	e law has b	nple	Utsurar A	CCIDENT						24a. Was autop	an 24b	. Were auto	psy findings available mpletion of cause of
	alF	ician: Th certificate rector, peg									perfor 1 ☐ Yes	2 No	1 Yes	2 No
	Χ	siciar certifirecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	in-1 0[7.50/0		Othe		th (Check only of			
	of	Phys er this eral di	2	27. Manner of Death	28a. Date of In		ER/Outpatien 28b. Time of		28c. Injury Work	4 🗆 Nursing H	ome 5 Resid			γ)
	ion	ath. r: Afte	atio	1 Natural 5 Pendin 2 Accident investig		ay Year)	Injury	м		res 2 □ No				
	Division of Vital Records,	or Atterde directo	Certification:	3 Suicide 6 Could i	not be ined 28e. Place of In building, e	njury - At l	home, farm, str	eet, facto	ry, office		28f. Location (S City or Tow	Street and Nun	nber or Rura	i Route Number,
	0	itai o urs aft rai Di led ir												
		To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) Certifyin 2 Medical	g Physician: To the bes Examiner: On the basis and manners	of examin	nowledge, death nation and/or in	n occurre vestigatio	d at the time on, in my op	e, date and place, pinion, death occur	and due to the or rred at the time, o	cause(s) and r date and place	manner as si e, and due to	tated. the cause(s)
		ithin 2 o the	Mec	29b. Signature and title of certifie		iaiea.		29	c. License	number		29d. Date sign	ned (Month,	Day, Year)
		with		1 h. 2	Vi MI	\			RES	- 000		7	7	2001
				30. Name and address of person	who completed cause of	death (Ite	m 23a) (Type.	Print)	,,,,,			1464	- 4	2006
		1		Wyel Hak		100	Loch	Ra	in	Blod,	MD.	Ba 1 tin	2760	21239
		Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	trar's Sign	nature	,						

			1- State of Maryland / Department of Health and Certificate of Death		ene 2006	20946			
	Physici	an	1. Decedent's Name (First, Middle, Last) Mary D. Wilson	2. Date of Death Month	Day Year	3. Time of Death 5:07 PM			
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat		4c. County of Deat				
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) It Under 1 Year If Under 24 Hrs	8. Date of Birth	n,				
b	Funeral Director		218-26-5585 1 M 2 MF 92 Yrs. Months Days Hours Min.			nplace (State or Foreign untry) .Carolina			
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
	Maryti i-f eho	tor	MD n/a Baltimore			1∭Yes 2 □ No			
	or 28s	Funerai Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Co	untry?			
	e 23e	erail	4728 Wakefield Road, Apt. 201 21216	Specific Ves or No.	USA 14. Race - Ame	rican Indian			
9	after d			to Rican, etc.)	Black, White				
5-0036	uret',	d by	3 Widowed 4 □ Divorced Year or Dates:		Am e	erican			
-5-	within 72 hours atter death with the Maryland ene. then "naturel", or Iteme 23e or 28e-f ehow Ite Marical Exerciting must be codified at	piete	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo	orking	Sb. Kind of Business/				
213	filed within Hygiene. Ither then	Completed by	6th Domestic		elf-Emplo	byed			
Maryland 2121	A d is b	Be c		me <i>(First, Middle, Ma</i> e Dickens					
ary	should and Men s marks umatic	Ţ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ri	ural Route Number, (City or Town, State, 2				
, S	l end 2 fealth a m 27 is		Clara L. Stanton/ Daughter 3123 Belmont Aven	A CONTRACTOR OF THE PARTY OF TH					
Baltimore,	Peges nent of h int: if Ite iry or of		20a. Method of Disposition 1		oc. Location - City or aurel, M				
altir	permit. Peges Department of Important: If I eny Injury or one	- 1	21. Signatura Funeral Serva Licensee 22. Name and Address of Facility Wy	lie F/H	P.A. of	Balto. Co			
8	\$2E\$8	1.2	Manual Page 1200 Liberty Rd.						
	Dhusisian		23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.	c or respiratory arres	τ,	Approximate Interval Between Onset and Death			
	Physician /Medical		Invinediate Cause Final disease or condition resulting in death) a. Sep 5 5 Due to (or as a consequence of):						
н	Examiner	_	S= uentially list conditions, if any, leading to immediate b. Due to as a consequence of):	al Heed 30					
	ansit an	Examiner	ra any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
, 0,	cate be executed physician and the burial-transit	i Exa	resulting in death) Last Due to (or as a consequence of):						
68760,	death certificate be executed e attending physician and and and for use as the burial-transit	edicai	d.		· ·				
Box (death certifica attending ph for use as th	M/Ne	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli				
	he dea the att	Physician/M	in the past 12 months? 1		Month	Day Year			
, P.O	res that the de signed by the a be detached t	by Ph		23e. Did toba	cco use contribute to	the cause of death?			
ords	law requires as been sign 2 should be	ted b	Hypertension	1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Unknown			
Division of Vital Records,	0 C B	Completed		24a. Was an autopsy performe	prior to d	topsy findings available ompletion of cause of			
ital		0	25. Was case referred to medical 36. Place of De	1 ☐ Yes 2	No 1 □ Yes	2□ No			
of V	itending Physician: death. tor: After this certifice the funeral director.	To B	examiner? 1 Yes 2 No	Home 5 ☐ Residen	ce 6 □Other (Spec	ufy)			
ono	Jing After fune	tion:	27. Manger of Death 12. Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 2 Accident investigation M 1 Yes 2 No	28d. Describe how	injury occurred				
Visi	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,			
ā	Hospital or A 24 hours after Funeral Directely filled in by	Cer	29a. Certifier Certifying Physician: To the best of my knowledge death occurred at the time, date and place						
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date of my knowledge, death occurred at the my knowledge of my knowledge, death occurred at the my knowledge of my	e, and due to the cau urred at the time, date	se(s) and manner as and place, and due	to the cause(s)			
	To the vithin 2 To the comple	Ž	29b. Signature and title of certifier 29c. License number	290	. Date signed (Month	, Day, Year)			
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	00	June !	30, 2006			
			South Towarthan Wesen Derson, M.D., Shai Hostol of lithingre, 2401 W	1. Pelvelere A	12, Baltimore	MD 217.15			
7	Sta		31. Date filed (Month, Day, Year)						
	Registr	al	JUL 0 5 2006 Secret St. 19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20947 State of Maryland / Department of Health and Mental Hygiene? [] [] [1 - For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Vear **Physician** Theresa Mary Wile 12:20 PM June 28, 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Co. 511 East Broadway Bel Air If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 1 F Yrs Director Jan. 27,1911 Maryland 216-42-6374 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or Items 23a or 28a-f show the Modical Examinar must be notified at 1 Yes 2 No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number United States 21014 511 East Broadway death Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status e filed within 72 hours after dail Hygiene.
other than "natural", or Item Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: Specify: White à 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Packer Manufacturing 8 Years other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Int: If Itam 27 Is marked o Rose Lawicki William H. Noonan ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Wile 511 East Broadway Bel Air, Maryland (Son) 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition tXXBurial 2 ☐ Cremation 3 ☐ Removal from State injury or permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Sacred Ht. of Jesus Cen. 7/3/2006 Jundalk, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEIDNOS Physician CAROAL ARRHATIONA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off Examine attending physician and of for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death signed by the at id be detached for 5 Other (specify) 1 Yes 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð ULLEN 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown ELVAINS Completed peen VASCUIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has t autopsy performed 2 No 1 Yes 2 No 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Ptace of Death (Check only one) Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 133088

Registrar

01

State

egistrar's Signature

1321 RIVERSIDE PRINT, SUITE A BETCAMP MA 2/017

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

BERNHARD BIRNGAUMA

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of I	Maryland / Dep <i>Ce</i>	ertificate of		d Mental Hy	giene Reg. No 0 0	6 20948
	Physic /Medi		1. Decedent's Name (First, Middle STEPHEN B		TE, JR			JULY	_	3. Time of Death 1:40 а м
	Exami	ner	4a. Facility Name (If not institution 3311 JARR	n, give street and numb ETTSVILLE	er) PIKE	4b. City, Town, o	or Location of De ONKTON	eath	4c. County of HARFO	Death RD
	Funeral Director		5. Social Security Number 219-28-5099	6. Sex 1 ☑ M 2 ☐ F	Age (In yrs. last birthday 8 4 Yrs.	Months Days	If Under 24 H Hours M			Birthplace (State or Foreign
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD HAR	FORD	10c. City, Town or L	ocation NKTON				10d. Inside City Limits 1 ☐ Yes 2 ☐ Xo
	h with the	ai Dire	10e. Street and Number 3311 JARR	ETTSVILLE	PIKE	10f. Zip Code 2 1 1 1	1 1		10g. Citizen of What USA	at Country?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23a or 28a-f show other traumatic event. Its Medical Experiment must be nutified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 Marriad 3 □ Widowed 4 □ Divorced	If Yes Give	T No W W	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		American Indian, White, etc. WHITE
21215-0036	hin 72 ho s. sn "natu	Completed	15. Deceden (Specify only highe: Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4	(Giv life.	edent's Usual Occup e kind of work done DO NOT use retired	during most of v d)	•	16b. Kind of Busin	ness/Industry
	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma		17. Father's Name (First, Middle,	5+	IN	VESTMENT			BANKIN , Maiden Sumame)	G
Maryland	should be and Mental marked of umatic eve	To Be	STEPHEN BO					DUISE DA		
	1 and 2 si Health and tem 27 is nother traur		CONSTANCE W		ife 331	1 JARRET		LE PIKE	er, City or Town, Sta MONKTON	nte, Zip Code) , MD 21111
Baltimore,	permit. Pages 1 and Depertment of Health Important: If Item 27 any Injury or other tr once.		20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other (S	pecify)	GREEN	MOUNT	07/		20c. Location - Cit	ORE, MD
Bal	Depermit Depermit Impor any In		21. Signature of Funeral Service	Licensee	2				JENKINS TON, MD	& SONS CO 21111
>	Physician /Medical Examiner	ilner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a	as a consequence of): 2 0 // 19 as a consequence of):		g, such as card	iac or respiratory a	rrest,	Approximate Interval Between Onset and Death
,8760,	icate be executed physicien and strength the burial-transit	dical Examiner	that initiated events resulting in death) Last		as a consequence of): ARKINJ		DI	EAJ'E	Фур. Miner and	2 days
P.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physicien and orage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 ☐ Fetal death 3 it at time of death 5 i	□Ectopic pregnancy □ Other (specify)			23d. Date o Month	f delivery Day Year
	w requires that been signed b should be dete	کر ا	Part II. Other significant condition	ns contributing to death	but not resulting in the d		en in Part I.	111		te to the cause of death? Probably 4 □Unknown
of Vital Records,		Completed		-				24a. Was autop perio 1 🗆 Yes	rmed?// deat	e autopsy findings available to completion of cause of h? Yes 2 \(\subseteq \) No
f Vit	ys dir	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpa	atient 2 ER/Outpatie	nt 3 DOA Othe	00	eath Check only of	one) dence 6 □Other (Specify
	ing After une		27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	9	njury 28b. Time o Day Year) Injury	of 28c. Injury Work			now injury occurred	эрөслү
Division		Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 286. Place of	Injury - At home, farm, st etc. (Specify)	reet, factory, office		28f. Location (S City or Tov	Street and Number o vn, State)	r Rural Route Number,
	Fur Pos	edicai (29a. Certifier 1 Certifyin (Check only one) 2 Madical	g Physician: To the be Examinar: On the basis and manner	st of my knowledge, deat of examination and/or in stated.	th occurred at the time	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within 2 To the complete	W	29b. Signature and title of certifier	42. 1V	10	29c. License			29d. Date signed (M	lonth, Day, Year)
	2×X		30. Name and address of person	me					1-5	2/0
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regi	f death (Item 23a) (Type, Syl), But Sylar's Signature	hade	ne	10W00	r MD	21204
DH	MH 17 Rev 1/2	_	JUL 0	5 2006	was D. A	The same of the sa				

ORIGINAL

Rashawn Anthony Waysome, Jr.

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Certific	ate of	Death				F	Reg No.	. 21	105	2094
Physici		1. Decedent's Name (First, Midd	le,Last)					-		2.	Date of De	ath			ime of Death
Medical Exam	iner	Rashawn A	Anthony V	Waysom	e, Ji	î •				- 1	Month June 28,	2006	Year	0	826 hrs
		4a. Facility Name (if not institution					b. City, Towr	, or L	ocation o	of Death		40	c. County o	f Death	
		Laurel Regional Hosp	ital			1	Laurel					F	Prince G	eorge's	
Funeral		5 Social Security Number	6. Sex	7. Age (In y	rs. last bir	thday)	If Under 1	Year	If Unde	r 24Hrs	8 Date of B	irth (MM.	/DD/YYYY	9. Birthpiad	ce (State or
Director		212-75-9310	1 X M 2 F				Months	Days	Hours	Min			2006	Foreign	
			1AM 2 F			Yrs.	5	5			Jan.	23,	2006	Courtily)	Maryland
y.		Usual Residence of Decedent 10a. State 10b. County		100	City, Town	or Locatio	in.							10d	Inside City Limits
* 3				- 1	•										Yes 2 X No
land f sho	ō		Arundel		Gler	Bur									res 2 X No
Maryland 28a-f show any d at once.	Director	10e. Street and Number					10f. Zip Cod	de				10g. Citi	izen of Wh	at Country?	
the l a or tiffe	這	210 Crain Co	ourt Circl	le, Ap	t. 1E	3		210	061				USA		
215-0036 be filed within 72 hours after death with the Maryland mal Hygiens he other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Funeral	11. Marital Status		cedent Ever i	n U.S.		Decedent o					0-	14. Race	- American Ir	ndian, Black,
leath r iten	ŭ,	1 XX Never Married 2 M	arried Armed F	orces?	0	If Ye	s, specify Cu	ıban, I	Mexican,	Puerto Ri	can, etc.)		White Z	Africa	n
fter de l'., or		3 Widowed 4 Div	orced If Yes, Give Yes		0	XX	Yes 2	No	specify:	Guat	malea	n		Americ	
21215-0036 build be filed within 72 hours after Mental Hygiene marked other than "natural", event, the Medical Examiner	d by	15 Decedent's Education (Spe	or Dates. cify only highest gra	de complete			s Usual Occ					16b.	Kind of Bus	iness/Indust	ry
72 ho	mpleted	Elementary/Secondary (0-12)	College (1-4 or 5+)		during mo	st of working	life. E	OO NOT	u s e retired	1)				
)36 hin 3 e thar	ğ	N/A				Inf	ant.						Tr	nfant	
d wit	S	17. Father's Name (First, Middle,	Last)					18	3.Mother's	s Name (F	irst, Middle,	Maiden			
215 e file al Hi ced o	Be	Rashawn A.	Waysome						ı	Maria	Elen	a Cı	ıellar	_	
21215-0036 uld be filed within 7 Mental Hygiene marked other than	To E	19a. Informant's Name/Relations			19	b. Mailing	Address (S	treet a							Code) 21061
MD d 2 sho lth and n 27 is		Tamara Cuellaı	c/Grandmot	her	- 4									Burnie	1.0
and 2		20a. Method of Disposition	- Granamo		Db. Place		ion (Name o				Date			City or Town	
Ore jes 1 of H if ii ther		1 XXBurial 2 Cremation	n 3 Removal fa			ory or oth								,	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygene Inimportant: If item 27 is marked other than " injury or other transmatic event, the Medical		4 Donation 5 Other S			Ivy E		Cemete				2006		urel,		
talt rmit epart npor jury		21. St hature of Funeral ervice	Licensee											Home,	I A.
ш жоз.=		Laurelan	reled	<i>_</i>	0160		3 Talb							20707	
Physician				aused the de	ath. Do no	ot enter the	e mode of dy	ing, si	uch as ca	ardiac or re	espiratory ar	rest, sho	ock, or hea		proximate Interval
/Medical Examiner	- 1	Immediate Cause (Final disease	failure. List only one cause on each line. Between Onset and Death Death												
ZXAIIIIIEI		or condition resulting in death)	Due to (or as a	a consequen	ce of):										
		Sequentially list conditions,	b												
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	a consequen	ce of):										
	Ē	Disease or injury that initiated	Due to (or as a	concedues	ne of):										
led l	ŭ	events resulting in death) Last	Due to (or as a	Consequent	Je OI).										
executed an and all - transi	g	UNPENDED	AMENDED												
8760, ifficate be executed by physician and is the burial - transit	n/Medical														
8760, rifficate be ing physicia as the buri	ξ	IF FEMALE: 23b Was decedent pregnant in the		outcome of p			.1	3	Estania	pregnanc		230	d Date of o	,	V
cert andir	siciar	past 12 months?		nant at time o		Feta		3	_Ectopic	pregnanc	у		Month	Day	Year
Box e death c the atten	ysic	1 Yes 2 No 9 Uni			`	Otn	er (Specify)					î			ï
rds, P.O. Box 6. requires that the death cert been signed by the attendit hould be detached for use?	Phy	Part II. Other significant condit	ions contributing to	o death but r	ot resultin	g in the ur	derlying cau	se giv	en in Par	rt I.	23e Did	tobacco	use contrib	oute to the ca	ause of death?
P.O.	ò							_			1 Ye	s 2 V	No 3	Probably	4 Unknown
lS, quire en siĝ	ted										24a. Was				findings available
cords, law requir has been s	ble										auto	psy	pr	ior to comple	etion of cause of
of Vital Records, ng Physician: The law requir the this certificate has been s neral director, page 2 should	Completed										1 V Yes	ormed? 2 N		eath? ✔ Yes	2 No
tal Re(cian: The certificate	O	25. Was case referred to medica	l l				26.P	lace o	f Death (Check onl	y one)		1 '		
Vital hysician: this certif	Ö	examiner?	Hospital: 1	Inpatient 2	✓ ER/O	utpatient	3 DOA	0	ther ₄	Nursing F	dome 5	Reside	ence 6	Other:	
n of \ ing Phy After th		1 ✓ Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b	Time of In	ury 28c.	Injury	at Work?		d. Describe			d	
on or or or or or or or or or or or or or	딍	1 Natural 5 Pend	Jun 28,	2006 (2006)	072	5 hrs	1	Ye	s 2 🗸	Nο Sι	ıbject sut	focate	ed on pla	stic bags	
SiC Atter r dear ector	cat	2 🗸 Accident Inves	stigation 280 Plac	e of Injury - A	At home fr	erm etroot	factory offi	oo bui	ilding oto	29	f Looption	Ctroot o	and Number	r or Dural Da	oute Number, City
Division of V pital or Attending Phous after death. eral Director: After tifiled in by the funeral	Certification:		d not be				, ractory, om	ce bui	iding, etc		or Town,	State)			dute Number, City
Spits hours nera	ပိ	4 Homicide	1,0000.197	Multi-Fa							0 Lauren		<u> </u>		
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for 1	ca	(Check only	nysician: To the beaminer:On the basis		-										(-)
Fo th vithii Fo th	Medical	4 150	and manner s		on and/or i	rivestigatio				Julied at ti	e time, date				
	Σ	29b Signature and title of certifie	+101	1 /7			29c. Lic					29d. l	Date signe	d (Month, Da	ay, Year)
		aral	HHI V	(Ink	M		0.	C.M	.E.			Jun	e 29, 20	06	
		30. Name and address of person	who c mpleted cau	se of death (Item 23a)		-1	-							
7		·	sistant Medical			Penn S	treet, Balt	imor	re, MD	21201					0.0
	tate	31. Date filed (Month, Day, Year)		egis g ar's Sig											
Regis			5 2006	Romer	1. 1	e A	18001								
5.4		<u> </u>	d	Action Control of			,							-	
Dalvin 17 Rev 1/2	.00				UH	IGINAL									

Ricky Lamond Williams

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006	209	5	Constant of
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		1-For State Registrar			C	ertifica	te of	Death_					eg. No	201		2000
Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year O038 hrs														
/ledical Exami	ner	RICKY	L.	WILLIAM	1S							June 30, 2	2006			0038 hrs
		4a Facility Name (if					4k	. City, Towr	n, or Lo	ocation of	Death		4c C	ounty of De	ath	
		Johns Hopki	ns Hospit	al				Baltimor	е				1	I/A		
Funeral		5. Social Security No	umber	6 Sex	7. Age (In yrs	s. last birtho	day)	If Under 1	Year	If Under	24Hrs. 8	B Date of Bir	th(MM/DD			ace (State or
Director		207 54 7	774	1 X M 2 F	3	3	Yrs	Months	Days	Hours	Min.	שמעט	10		eign Countr	y)
	- 1			I A IVI Z F			113				<u> </u>	SEPT.	12,	1972		PA.
ģ	ŀ	Usual Residence of 10a State	10b. County		10c. C	ity, Town or	Locatio	n							10	d Inside City Limits
. A		MD.	N/	/ 7											1	X Yes 2 No
Maryland 28a-f show any d at once.	ğ					BAL	L. T M(40			1 1	Og Citizor	n of What C	ountry'	2
Mary 28a- d at	Director	10e Street and Num 1231 N.		OMAC CITE	REET			10f. Zip Coo	12	12		- ['	og Citizei		Juliliy	
with the Maryland ns 23a or 28a-f sho be notified at once.		IZJI N.	FOI	JHAC 511										USA		
with the ms 23a be noti	Funeral	11. Marital Status		A amount f	cedent Ever in	US	13. Was	Decedent o s, specify Ci	f Hisp	anic Origii Mexican	n? (Spec Puerto Ric	ify Yes or No can_etc.)	- 14	Race - Am White, etc		Indian, Black,
or iter	Ĕ	1 XNever Marrie	d 2 M	arried 1 Yes	2 X No											
ifter II", o	by F	3 Widowed	4 Div	orced If Yes, Give Ye	еаг		1'	Yes 2	No	specify:			Sp	ecif B LA	.CK	
hours afte 'natural", Examiner		15 Decedent's Ed	ucation (Spe	cify only highest gra	ade completed			s Usual Occ st of working					16b Kın	d of Busines	ss/Indu	stry
72 hc	Completed	Elementary/Secon	ndary (0-12)	College	(1-4 or 5+)		aring ino	31 01 44 011(11)	,	30 110 7 0	100 1011100	,				
15-0036 filed within 72 I Hygiene. d other than "	덴	11TH					LAB	ORER					CON	ISTRU	CT.	ION
5-0(ed wi lygie other	S	17. Father's Name (First, Middle	, Last)					18	3 Mother's	ner's Name (First, Middle, Maiden Surname)					
21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'e event, the Medical	Be	RICKY	MC W	ILLIAMS						CONS	STAN	CE = W	ILLI	AMS		
2121 Duld be fi Mental I marked	၉	19a. Informant's Na	me/Relations	ship (Type, Print)		19b.	Mailing	Address (S	Street	and Numb	er or Rur	al Route Nur	nber, City	or Town, St	ate, Zir	Code)
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygene. item 27 is marked other than "natural", or items 23a or 28a-f short traumatic event, the Medical Examiner must be notified at once		CONSTAN	CE WE	BSTER/m	other	2	419	W. I	ex	ingt	on	St. Baltimore, Md. 21223				
e, h l and Healtl item	1	20a. Method of Disp				b. Place of	Disposit	ion (Name c				ate	20c. Lo	cation - City	or Tov	vn, State
DC ges 1 it of	The state of the s										v 5	2006	_{D A T}	ФТМО	DГ	MD
timent trans																, MD .
Balti permit Departm Imports injury	1 7	160	/	11	Line a		CA	LVIN	В.	SCF	RUGG	S FUN	ERAI	_ HOM	E	
	The state of the s											ST B	ALTC	MD or heart		pproximate Interval
Physician /Medical	ĺ	failure. List onl	y one cause	e on each line						deri de ed		,,		, -, ,,===		Between Onset and Death
xaminer	1	Immediate Cause (I			n And Al		Intox	ication	1						-	Death
		or condition resultir	ig in dealir)	Due to (or as	a consequenc	e of):										
	<u></u>	Sequentially list con		Due to (or as	a consequenc	e of):			_						+	
	ine	cause. Enter Unde	rlying Cause		a concoquenc										-14	
Ţ	Examiner	(Disease or injury the events resulting in			a consequenc	ce of):									\neg	
zuted nd ransi				d												
8760, tificate be executed ng physician and as the burial - transii	n/Medical	X UNPENDED		AMENDED	item#2	3a,27,	28a-f	perME,	, g 85	7,7/1	.0/06	IΤ				
8760, tificate be ng physic as the bur	Nec	IF FEMALE:		23c. If yes	, outcome of p	regnancy	_						23d	Date of deliv	/ery	
∞ ≒ 20 €		23b Was decedent past 12 months		LIVE	birth	2	Fet	al death	3	Ectopic	pregnanc	У	М	onth	Day	Year
x 6 th ce trend	i.i.	1 Yes 2		din euro	gnant at time o	f death 5	Oth	er (Specify))							1.5
ords, P.O. Box 68. w requires that the death certification is been signed by the attending should be detached for use as	Physicia			a CONK							4.1	Taba Dida		o opposibilita	to the	cause of death?
O. O. od by etach	by P	Part II. Other signi	ficant condi	itions contributing	to death but n	ot resulting	in the ur	nderlying ca	use gi	ven in Par	τι.					y 4 V Unknown
res the signed be d												I Te	s 2 1	NO 3 F	robabi	y 4 V OTKNOWN
rds requi	ete											24a. Was auto				sy findings available pletion of cause of
CO s law	Completed			-								perfo	rmed?	death 1 🗸	۱۶	2 No
Re Theath freath	ပိ	25 10/22 222 2252	sed to media	al T				26.1	Place	of Death /	Check on		2 110	' 🔻		2 110
tal ician certi	Be	25. Was case refer examiner?		Hospital:	Inpatient 2	► EB/Ou	tentiont		10	Other ₄		Home 5	Residenc	· 6 0	ther:	
of Vital Records, P.(ing Physician: The law requires tha After this certificate has been signed funeral director, page 2 should be det	유	1 Yes 27. Manner of Deat	2 No	1	, ,		ime of Ir			at Work		8d. Describe				
Ing ling Afte	ä	1 Natural			te of Injury hth, Day, Year)			`		es 2			,,			
ttend death ctor:	ă	2 Accident		estigation	/30/2006		12:13			21		uk	01	1 1 1 1	David	D. t. North of City
Division of Vital Records, P.O. Box 6i tal or Attending Physician: The law requires that the death cert rs after death: "I Director: After this certificate has been signed by the attending left in by the funeral director, page 2 should be detached for use a left left in by the funeral director, page 2 should be detached for use a	i <u>i</u>	3 Suicide		lid not be	ace of Injury - A		rm, stree	t, factory, of	fice bu	ulding, etc		or Town,	Street and State) 2	38 Beth	el (Route Number, City
Divisior pital or Attend ours after death teral Director: filled in by the	Certification:	4 Homicide		ermined (Specif								Baltimo				
Hos 24 h Fun etely		29a. Certifier 1	Certifying F	Physician: To the b	est of my know	vledge, dea	th occur	red at the tin	ne, da	te and pla	ce, and di	ue to the cau	se(s) and	manner as s	started	21150(6)
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attentificance of Filed in by the funeral director, page 2 should be detached for use.	Medical			aminer: On the basi and manne	s of examination	on and/or in	ivestigat				Jurred at t	ne time, date				
- × + ×	Me	29b Signature and	title of certif	ier						number				ate signed (Day, Year)
		une	177).C.N	Л.Е.			June	30, 2006	1	
Observed		30 Name and add	ress of perso	n who completed ca	ause of death (Item 23a)										
10.00		Ana Rubio	_	sistant Medica		111 F	enn S	treet, Ba	timo	re, MD	21201					
	State	31. Date filed (Mon	th, Day, Year	2 0000 32.	F gistrar's Sig	natur	1	we	_							
Regi		1	JUL 0	5 2006	BUNNE	15	1400									

		1 - For State Registrar	State of Marylan		rtment of F ificate of			giene Reg. No.	006	2095	
Physi	ician	Decedent's Name (First, Middle, Last					2. Date of Dea	Day	Year	3. Time of Death	A
/Med Exam	dical	EVELYN Viola 4a. Facility Name (If not institution, give	Street and number)		4b. City, Town, o	or Location of Deatl	June		2004 ounty of Death	2,10	<u>. </u>
LAdii	iiiiei	1506 Bradchuc	- 4		Fores				Harf	ord	
Funera	al	5. Social Security Number 6. Se			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th v. Year)	9. Birth	place (State or Foreig	ın
Directo	or	100-20-6056	JM 200F 77	Yrs.			June 1, 1		Pen	sylvania	
land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loca	ation					10d. Inside City Limits	
Mary f sho	to	Maryland Harfo	rd	For	est Hill					1 ☐ Yes 2 No)
h the	Directo	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	intry?	_
ith wit		1506 Bradchuc	K Ct.		210	50			USA		
or dea	Funerai	11. Marital Status	Was Decedent Ever in U. Armed Forces?	S. 13. W	as Decedent of H Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	- 14	. Race - Amer Black, White		
36 rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	1 (Yes 2 No	Specify:		S	pecify: 1/1		
laryiand 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Iteme 23a or 28a-f show aumatic event, the Medical Examinat must be rigitized.	ed	15. Decedent's Edu	ıcation	16a. Decede	nt's Usual Occup	pation		16b. Kind	of Business/li	ndustry	_
215 Pin 73 In 'n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	le completed) College (1-4or 5+)	(Give ki	ind of work done O NOT use retire	during most of wor d)				,	
21 with gions of the state of t	Son		4	Senior	System	s Progra	emer		IBM		
be file doth	Be	17. Father's Name (First, Middle, Last)	00 1 11				ne (First, Middle,				
Maryla d 2 should th and Men 7 Is marke traumatic	2		ffstall	105 14-111-	Add (0)		lamina				_
Man d 2 st th and 17 Is n traun	1	Bradley Austin	50 n			and Number or Ru					
Baltimore, Maryland 27 sernit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie mportant: If Item 27 is marked other to my injury or other treumatic event.	1	20a. Method of Disposition		lace of Disposi	tion (Name of atory or other place	ruck CT,	Date	20c. Loca	ition - City or T	own, State	_
TO Pages ent of to fr		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 🗷 Donation 5 ☐ Other (Specify)	Removal from State			try June					
Baltimo permit. Pag Department Important: f		21. Signature of Funeral Service Licens		22.	Name and Addre	ss of Facility A	no tomu G	1:645	Registi	U	-
Depariment	ă	1/500		752	2 Conne	Hey Drive	svite P.	House	ver, M	\$ 21076	
		23a. Part1. Enter the disease, or composhock, or heart failure. List only o	lications that caused the death	n. Do not enter	the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between	
Physicia		Immediate Cause (Final disease or condition	. Preumo	nia						Onset and Death	
/Medica Examine		resulting in death)	Due to (or as a conseq	uence of):	1						
* 38	Table 1	Sequentially list conditions,	b. <u>Cerebrei</u> Due to (or as a consequ	Juscula	ar M	ecident					_
/8/ pg list	m lu	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Hyperter								
execun and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence								
ate be executed obysicien and the burial-transit	dical		d								
rtifica		IF FEMALE:									
BOX 61 eath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1☐Live birth 2☐Fetal	death 3 E	ctopic pregnancy	,		230	d. Date of deliv	rery Day Year	
the a	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of di 9□Unknown	eath 5 🗌 (Other (specify) _				Worter	Day Tour	
Hecords, P.O. Box 61 The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as in		Part II. Dther significant conditions co	ntributing to death but not resi	ulting in the und	lerlying cause giv	ren in Part I.	23e. Did to	obacco use	contribute to	the cause of death?	
dS, luires n sign	d by	Denvession					1 🗆 Y	es 2 21	No 3□Pro	bably 4 \(Unknown	1
cord w require been si	jete	Darinheral	neuropathy				24a. Was	an 2	24b. Were aut	opsy findings available	 e
He ta	Completed	Perspica	The state of the s				autop perfor	rmed?	prior to co death?	ompletion of cause of	
	BeC	25. Was case referred to medical				26. Place of Dea	th (Check only of	ne)	1 🗆 Yes	2 No	
hysic hysic his ce	10	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 I	ER/Outpatient	3□ DOA Oth	ler: 4 ☐ Nursing H	ome 52 Resid	lence 6[Other (Speci	fy)	
ing P	in o	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe h	now injury o	occurred		
ISIO trend death stor: /	icati	2 Accident investigation 3 Suicide 6 Could not be	29a Blood of Injury. At he			Yes 2 □ No	Ogt Location (C			10	
DIVISION OF VITAL RECORDS, t or Attending Physician: The law requires t after death. Director: Atter this certificate has been signe din by the funeral director, page 2 should be	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, iarm, stree ()	вт, гастогу, опісе		City or Tow	vn, State)	vumber or Hur	al Route Number,	
spita hours neral		29a. Certifier 1 Certifying Phy	sician: To the best of my kno	wledge, death o	occurred at the tir	ne, date and place	, and due to the o	cause(s) an	nd manner as s	stated.	
DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, i	edical	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	tion and/or inve	stigation, in my o	pinion, death occu	rred at the time, o	date and pl	ace, and due t	o the cause(s)	
To ti withii To ti comp	ž	29b. Signature and title of certifier	Aly . In I		29c. Licens				signed (Month,		
1		/	1 Charles			59387		06-	30-2	2006	
l	P	30. Name and address of person who co									
670) 6		31. Date filed (Month, Day, Year)	2 Colgate	Drive 5	suite 203	3 terest 48	U.MD	2105	00		
Regis	State strar	nu 0 6 2006	32. Registrar's Signa	Good	e P						

			1 - For State Registrar	State of Marylar		artment of rtificate o			giene	106	20952
	Physic /Medi		1. Decedent's Name (First, Middle, Last,	ADI	ER			2. Date of De. Month	ath Day	Year 906	3. Time of Death
	Examir Funeral Director	ier	4a. Facility Name (If not institution, give Keswick Mul. 5. Social Security Number 6. Set 379–20–1039	HI-Care Ce	last birthday) 80 Yrs.		or Location of D MOC ar If Under 24 rs Hours	MD 2121 Hrs. 8. Date of Birt Min. (Month, Da	h Back	9. Birthpla	ade State or Foreign
		_	Usual Residence of Decedent 10a. State 10b. County	ard Co.	ty, Town or Lo		umb i a	Feb. 7	, 1926		nigan od. Inside City Limits
	vith the Ma t or 28e-f	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		,
36	hours atter death with the Maryland turel', or liteme 23a or 28e-f ehow al Exactical count be notified at	by Funerai	6100 Holly Ridge C 11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 2 2 2 2 3 2 2 3 2 3 2 3 2 3 2 3 2 3	'	Was Decedent of Yes, specify C	f Hispanic Origin uban, Mexican, P	7 (Specify Yes or No- uerto Rican, etc.)	Bla	US ce - America ck, White, er	n Indian, tc.
21215-0036	within 72 ene. then "nat	Completed b	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occ kind of work dor DO NOT use reti Homema	e during most of red)	working	16b. Kind of 8	usiness/Indu	
Maryland 2	uld be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Elliott Knox			Tionena	18. Mother's	Name (First, Middle, azel G.			
d)	and 2 sho fealth and I im 27 le mu her treumu		19a. Informant's Name/Relationship (Ty, Judith Jaquis 20a. Method of Disposition	Daughter	6100			r Rural Route Numbert Columb	oia, Mai	ryland	21044
Baltimore,	t. Page nment o ntant: If njury or		### Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	emoval from State C1	over H	ill Parl	s 7/	Date 7/2006 I	20c. Location Birmingl	•	n, State lichigan
Ba	Dermi Depe fmpo fmpo eny la	i), a	23a Part 1. Enler the disease, or complishock, or heard allure. List only or	Denter	B 3	osi rai.	enss-Sei Is Road	tz Funeral Baltimo	ore. Mai	y Land	21211 Approximate
28760,	Physician /Medical Examiner but stee price and stee transit stee price and stee	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	varct vascu vascu uence of):		disa				nterval Between Driset and Death Graves Graves
.O. Box	es that the death certifi igned by the attending be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, oulcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	Ectopic pregnan Other (specify)	су			te of delivery nth Di	, ay Year
ords, P	The law requires that the ate has been signed by th bage 2 should be detache	Ď	Part II. Other significant conditions con	tributing to death bul nol res	ulting in the ur	nderlying cause o	iven in Part I.	23e. Did Io		ribute to the	cause of death?
		Completed	OF Was seen relevant to market						Tod?	Were autops prior to comp death?	y findings available pletion of cause of
Vital	ysicie is cert directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	ospital: 1 ☐ InpatienI 2 ☐	ER/Outpatient	3 □ DOA O		Death Check only on g Home 5 Reside			
Division of	ding Ph h. After th funeral	ation: T	27. Manner of eath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. inj		28d. Describe ho			
	Hospitel or Atten 4 hours etter deat Funerel Director: tely tilled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	v) 			28f. Location (Si City or Town	n, State)		
	To the Hospitel or Al within 24 hours etter of To the Funerel Direc completely tilled in by	Aedicai	one)	ician: To the best of my kno ler: On the basis of examina and manner stated.	wledge, death tion and/or inv	estigation, in my	opinion, death of	ace, and due to the cocurred at the time, d	ause(s) and ma ate and place, a	nner as state and due to th	e cause(s)
)	5 ¥ 5 00	2	29b. Signature and title of certifier endall	Facelle	ers	Da	5643	,	9d. Date signed	3/20	y, Year) 20 b
	5		Kendale Riaulb	mpleted cause of death (Item MD 656	5 N,	Charles	s St Su	uteday	Balte	M	21204
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture	all.		/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#5 berFH 0857.7/6/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2 Date of Death 3. Time of Death Year **Physician** 12:56PM ad USZ Adamis 07 00 /Medical County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore althmore ND University of Meryland Medical Center 9. Birthplace (State or Foreign Country)
Poland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/3/194 5. Social Security Number 2374 6. Sex 7. Age (In yrs. last birthday) **Funeral** 33 S 18M 20F Days Hours 578. 08 Yrs. Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Itema 23a or 28a-1 ehow eny injury or other traumatic event, the Madical Exportment must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Baltimore 1 Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 921 Church Street 21225 Poland 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Body Shop Brown's Honda City 4 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stefania Smialek Stefan Adamus ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Krystyna Adamus / wife 921 Church Street Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 7/7/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4001 Ritchie Highway Baltimore, Maryland 21225 come monlecelle Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiogenic **Physician** disease or condition resulting in death) /Medical Due to (or as a sensequence of) Examiner Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Examiner Due to (or as a consequence of or Attending Physician: The law requires thet the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical signed by the ettending I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy 2 No 1 ☐ Yes 1 ☐ Yes 2 No tuneral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Pres 2 □ No 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D61418 poleted cause of death (Item 23a) (Type, Print)

State Registrar

30. Name and address of person 31. Date filed (Month, Day, Year)

M.D

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DIVISION

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			1 - For State Registrar			nd / Depa	artment of H	lealth a	and M	lental Hyg	iene	06	20954		
	5 200	MI.	Negistrar Decedent's Name (First, Middle	e, Last)			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-		2. Date of Deat	h _		3. Time of Death		
	Physicia		Margaret	Inez	Abbott					July	O1°	2006	9:45 A M		
	/Medic Examin	1 acc	4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City, Town, or		of Death			y of Death			
			Hammonds Lane	Nursing H	Home		Brook1	0				e Aru			
1.5	Funeral Director		5. Social Security Number 217-05-9140	6. Sex 1 ☐ M 2 ☐ X F	7. Age (In yrs.	last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day NOV 19	1918	9. Birthp Cour	place (State or Foreign NC		
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. C	ty, Town or Lo	cation					1	0d. Inside City Limits		
	e Maryis Ba-f sho	ctor	Maryland Ann	e Arundel				Pasad	ena				1 _ Yes 2 No		
	h with th	al Dire	10e. Street and Number 8448 Alvin Ro	ad			10f. Zip Code	21122		1	0g. Citizen of	USA	ntry?		
36	rs after deal	by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3X Widowed 4 Divorced	Armed F ned 1 ☐ Yes	2 □ X No ive	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Ori an, Mexicar Specify:		ecify Yes or No- Rican, etc.)	Bla	ice - Americack, White,	etc.		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If tem 27 is marked other than "natural", or teme 23a or 28a-f show amply injury or other traumatte event, I're Medical Examination and be inclined an once.	Completed	15. Deceder	it's Education st grade completed	1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired HOMEMAK	during mos 1)	et of work	ing	16b. Kind of I	Business/In			
nd 21	oe filed wall Hygiel dother the	Be Col	17. Father's Name (First, Middle,	Last)			Tollellar		er's Name	e (First, Middle, I	Maiden Suma	me)			
Уlа	ould I Men narke	ဥ	George Cam		Fadyen	10h 14-16	ng Address (Street		nie	Bell		Grime			
, Mar	and 2 shalth and 27 is n		19a. Informant's Name/Relations Bruce Abbott	(Son)		23 Bi	riar Ct.	Hambu	rg N	lew Jerse	ey o741	9			
more	ages 1 aent of He		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S				osition (Name of matory or other place Cem.	ce)	7/7/		20c.Location Baltimo				
Balti	permit. I Departm Importal any infu		21. Signatur ov-uneral Service	Licentee	u.	3		ain R	Rd. P	asadena	, Md. 2		e PA		
	Physician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	disease or condition											
,092	death certificate be executed as attending physicien and dror use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ————————————————————————————————————	(or as a conse	quence of):									
.O. Box 68	The law requires that the death certifica sie has been signed by the attending ph bege 2 should be delached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	1 Live	utcome of pregr birth 2 Fet mant at time of nown	al death 3[□Ectopic pregna <i>n</i> cy □ Other (<i>specify</i>)	'				ate of delivionth	ery Day Year		
0.	w requires that been signed b should be deta	þ	Part II. Other significant conditions Adulance		en ton tud daab	sufting in the L	inderlying cause giv	en in Part I	l.		pacco use coi es 2 □ No		he cause of death?		
I Records,		Completed								24a. Was a autops perform		prior to co death?	opsy findings available impletion of cause of		
Vital	Physicien: Th this certificete ral director, peç	Be (25. Was case referred to medica examiner?				104			h Check only on					
of/	shys this aldi	2	1 Yes 2 No		Inpatient 2 [ER/Outpatie		4 () 140		ome 5 Reside			(y)		
	ing After une	tlon	1 Matural 5 ☐ Pendi	(AAn	nth, Day Year)	Injury	Wor	k? Yes 2□		28d. Describe no	ow injury occi	11180			
Division	if or Attending after death. Director: After	Certification:	3 Suicide 6 Could	not be 28e. Plac	e of Injury - At ding, etc. (Spec	nome, farm, st ify)	reet, factory, office			28f. Location (Si City or Town		ber or Run	al Route Number,		
i	Hospite 4 hours Funerel ely filled	edical Ce	29a. Certifier Certifyi (Check only one) Medica	ng Physician: To the Examiner: On the and ma	e best of my kr basis of examin	owledge, dea ation and/or in	h occurred at the tirevestigation, in my d	me, date ar opinion, dea	nd place, ath occur	and due to the cred at the time, d	ause(s) and nate and place	nanner as s , and due t	stated. o the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certific	ər	,		29c. Licens	e number		2	9d. Date sign	ed (Month,	Day, Year)		
	n		1//		WE	> 00:17	Dailer)	> 54	62	-	71	3100	21061		
	'2		30. Name and accress of person		use of death (Ite	т 23a) (Туре 8 ч С	Printi	۲۸	Ras	مای کم	n Bi		W C		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year	6 2006	Registrar's Sign	nature A	29c. Licens D. Print) Print	<u> </u>	· ~~			MIC	TT S James		

06-04464 Please Type or Print in Black Indelible Ink Thomas Henry Batty State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year **Medical Examiner** dward June 26, 2006 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Lobby of 301 McMechen Street Baltimore Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) Date of Birth (MM/DD/YY 9. Birthplace (State or **Funeral** Months Days Hours Min. Director 219-38 Usual Residence of Decedent 10b. County 10c. City, Town or Location Inv "natural", or items 23a or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho d altimore Director 10e. Street and Numbe 10g. Citizen of What Country 21217 39 Funeral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married Yes Black traumatic event, the Medical Examiner Widowed Divorced If Yes, Give Year 1 Yes 2 No specify: ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Inom as swowd 19a. Informant's Name/Relationship (Type, Pr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) # 518 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 2 Cremation 3 Removal from State permit. Pages Department o mportant: Donation 5 Other Specify: 10/06 21. Signature of Funeral Service Licensee Chatman - Harris Rd Baltimore 5240 heisterstown Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line /Medical a Gunshot Wound of Head and Neck Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial -23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 1 🗸 Yes 25, Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other Scene 1 V Yes 28a. Date of Injury (Month, Day Year) Jun 26, 2006 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

0805 hrs

10d. Inside City Limits

Approximate Interval

Between Onset and

Death

Year

Day

28f. Location (Street and Number or Rural Route Number, City

or Town, State)
Lobby of 301 McMechen Street, Baltimore, MD

June 26, 2006

29d. Date signed (Month, Day, Year)

Subject shot

1 ✓ Yes 2 No

29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Yes 2 No

Country)

Division of Vital Records, P.O. Box 68760, After this certificate has been s funeral director, page 2 should I funeral director,

filled in by the

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi

Certification:

Medical

one)

Natural

Accident

Suicide

4 V Homicide 29a. Certifier 1

29b. Signature and

State

Registrar

Susan Hogan MD. 31. Date filed (Month Day(Year) 2006

30. Name and address of person who completed cause of death (Item 23a)

5 Pending

Could not be

Assistant Medical Examiner 32! Registrar's Signatore

(Specify) Multi-Family Apt.

0800 hrs

28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

			For State Registrar	State of M	aryland /		irtment of H tificate of L			giene Reg. No.	006	20956
	Physici	an	Decedent's Name (First, Middle, Last	_					2. Date of Dea Month	ath Day	Year	3. Time of Death
700	/Medi		NORMAN	BENJ	AMIN				6	30	2006	12:50 p M
	Examir	ier	4a. Facility Name (If not institution, give Maryland General				4b. City, Town, or Balto	Location of Deat	h		nty of Death /A	
	Funeral Director		5. Social Security Number 6. Se 17 218-01-5523	x 7. Ag ☐ M 2 ☐ F	e (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 8 26	1, Year) 1915	9. Birthi Coul	place (State or Foreign A1
	Pu ≱		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation					I 0d. Inside City Limits
	Aaryla Peter	ō	,	I/A		timo						Yas 2 No
	28a-	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	of What Cou	ntry?
	h with	a D	2018 Braddish Aver	nue			21216			U S	S A	•
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at 2006.	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		lt lt	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. R B	ace - Americ lack, White, cify:	
2	72 ho	eted	15. Decedent's Edu (Specify only highest grad		16	(Give I	ent's Usual Occupa	luring most of wor	tkina	16b. Kind of		,
2	vithin ne. han "	mpl	Elementary/Secondary (0-12)	Colfege (1-4or		life. L	OO NOT use retired shoreman)	9	Stea	amship	Trade
	Hygie Hygie ther t		12th grade 17. Father's Name (First, Middle, Last)		N/A			18 Mother's Nan	ne (First, Middle,	Maiden Sum	ama)	
Maryland	ental Bontal Ked o	To Be	Henry C. Benjamin	1					Robins		ame	
ary	shoul ind Mari i mari	-	19a. Informant's Name/Relationship (T)		1:		g Address (Street a					Code)
	and 2		Dorothy Benjamin	- Wife		352	2 Milford	l Mill Ro	oad Balto	o, Md	21244	
Baltimore,	Pages 1 a ent of He nt: ff Iten ry or oth		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	ceme	tery, crem	sition (Name of latory or other place orial Par		Date 2006	20c. Location		
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service Licens		ke.	22.	Name and Addres		arch F/H nue Bal		21215	£
	15.4		23a. Part 1. Enter the disease, or comp shock, or head failure. List only o	lications that cause	the death. D	o not ente	er the mode of dying	g, such as cardiac	or respiratory are	est,		Approximate
i ja	Physician /Medical	0.0	sn ex, or hear filtre. List only o Immediate Cause (Final disease or condition resulting in death)	HYPER		£ C1	troiova.					Interval Between Onset and Death
	Examiner		Sequentially list conditions	b								
	sit s	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequenc	e of):						
_	and and il-tran	xarr	that initiated events resulting in death) Last	c. Due to (or as	a consequenc	e of):					-	
8760,	licate be executed physicien and s the burial-transit	alE		4		,-						
189	ificate g phy as the	edical		u								
P.O. Box	or Attending Physician: The law requires that the death certific leads. Director: After this certificate has been signed by the attending plus by the tuneral director, page 2 should be detached for use as in by the tuneral director, page 2.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. ff yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)				Date of delive Month	ery Day Year
	juires that the de n signed by the a lid be detached f	þ	Part II. Other significant conditions co.			j in the un	derlying cause give	n in Part I.		bacco use co		ne cause of death?
S	w require been si should t	lete	ANEMIA	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					24a. Was a			psy findings available
Re	he lav e has age 2	Completed	7117 27117 7						autop:	med? -	prior to con death?	inpletion of cause of
ta	ysician: The is certificate hidirector, page	0	25. Was case referred to medical					26 Place of Dea	1 ☐ Yes	700	1 🗌 Yes	2∐ No
<u>=</u>	nysici lis cer direc	To B	examiner? 1 🗆 Yes 2 🗓 No	lospital:	nt 2 DERV	Dutpatient	3□ DOA Othe		ome 5 Resid	***	ther (Specifi	<i>(</i>)
Division of Vital Records,	Attending Ph or death. Octor: After the by the funeral		27. Manner of Death 1 ☑Naturaf 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ry 28b <i>Year)</i>	. Time of Injury	28c. Injury Work M 1 TY		28d. Describe h			
Divis	al or Atte s after de l Directo d in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, c. (Specify)	farm, stre	et, factory, office		28f. Location (S City or Town		nber or Rura	I Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best ner: On the basis of and manner sta	examination a	ge, death and/or inv	occurred at the tim estigation, in my op	e, date and place inion, death occu	, and due to the c rred at the time, d	ause(s) and r ate and place	manner as st	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier				29c. License	number	2	9d. Date sign	ned (Month,	Dey, Year)
	m		blun m.s				Dovs	9107		07-0	5-2	.006
	5		30. Name and address of person who co					•	STONN	mo :	21136	
6	Sta	201	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1	<i>N</i> .				, , , ,	
Į.	Registr	ar	HH 0 6 2006	Ser 160		4304						

			For State Registrar	State of	of Marylan	d / Depa <i>Cer</i>	irtment of H tificate of L	ealth and I D <i>eath</i>		jiene2 ()	06	20957
			1. Decedent's Name (First, Middle	e, Last)					2. Date of Dea	th Day	Year	3. Time of Death
	Physicia /Medic		Bennie	Baahi					Month		006	6:07 PM
	Examin		4a. Facility Name (If not institution	, give street and hu	ımber)		4b. City, Town, or	Location of Death		4c. County	of Death	
		•	University of	Marylan	d Medical	lenter	Baltin	ore.		1	IIA -	
Ħ	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Vanel	9. Birthpla	ace (State or Foreign
	Director	1	242-58-4267	1 □ X M 2 □ F	6	7 Yrs.	Months Days	Hours Min.	(Month, Day	1938	Countr	Carolina
			Usual Residence of Decedent							1000		Odiolaid
	ylan		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10	d. Inside City Limits
	Mar - Mar	ģ	Maryland	N/A			Ba	altimore				1 XYes 2 No
	1 the	Je C	10e. Street and Number				10f. Zip Code			log. Citizen of W	/hat Countr	y?
	39 of	Funeral Director	3031 Piedmont Ave	nue				21216			U.S.A	
	rs 2:	era	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13. V	Vas Decedent of Hi Yes, specify Cuba		pecify Yes or No-	14. Race	- America	
_	19 TH	2	1 ☐ Never Married 2 ☐ Married	Armed F		l II	Yes, specify Cubai	n, Mexican, Puert	o Rican, etc.)	Blac	k, White, e	tc.
200	rrs a	ğ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	2 ☐ No ive Dates: 46	957	☐ Yes 2☐XNo	Specify:		Specify	В	lack
ş	ture in	e	15. Deceden	t's Education		16a. Deced	ent's Usual Occupa	ation		16b. Kind of Bu	siness/Indu	ıstrv
2	i -	plet	(Specify only higher	st grade completed,		(Give	kind of work done of OO NOT use retired	luring most of wor)	rking			,
7	the end	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)		Line	Mason		Di	amond	Sugar
5	Hyg Hyg other		17. Father's Name (First, Middle,	Last)				18. Mother's Nan	ne (First, Middle,	Maiden Sumam	e)	
<u>a</u>	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heatil and Menial Hygiene. Department of Heatil and Menial Hygiene. Important: If then 27 le marked other then "natural", or items 23e or 28e-f ehow any injury or other traumetic event, the Medical Examinar must be molified at once.	To Be	Be	nnie Bagby					Sa	arah Reed		
<u> </u>	M M M	_	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Street a	and Number or Ru	ırai Route Numbe	. City or Town,	State, Zip C	Code)
2	d 2 d d d d d d d d d d d d d d d d d d		Eunice Bagby Wife				31 Piedmont					
ນົ	Heal Heal		20a. Method of Disposition		20b. F	Place of Dispos	sition (Name of	1	Date	20c. Location -		n, State
2	if it		1 MBurial 2 Cremation		State		natory`or other place		07/07/06			
	trant		4 □ Donation 5 □ Other (S	/		-	Memorial Pa		07/07/08	AAII	dsor Mi	iii, ivia.
<u> </u>	Dermi Depa Impo In ir		21. Signature of Purietal Service	Circuisad	0/0			,	eral Service	РΑ		
	40240		23a. Part1. Enter the disease, or	0.8	XII	1	1300 E	Itaw Place E	eral Service, Baltimore, Mo	21217		
			shock, or heart failure. List	only one cause on	each line	n. Do not ente	er the mode of dying	g, such as cardiad	or respiratory are	est,		Approximate Interval Between Onset and Death
٦ ا	hysician		Immediate Cause (Final disease or condition	Pr	ostate	Car	rcer					5 URars
	/Medical		resulting in death)	Due to	(or as a conseq	uence of):						9
	Examiner		Sequentially list conditions,	b								
•	D =	Examiner	if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseq	uence of):						
7	cute	am	Cause (Diseese or injury that initiated events	C								
کِ آ	a exe ia∩ a urial-i	EX	resulting in death) Last	Due to	(or as a conseq	uence of):						
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Š	th ce r use	an/	23b. Was decedent pregnant		itcome of pregna birth 2 Peta		Ectopic pregnancy				of delivery	·
	dea ed fo	SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of d		Other (specify)			Mor	ith L	oay Year
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Ĕ	The I te ha	Completed							autops perfor	med? d	eath?	pletion of cause of
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>	s cer direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outnatient	t 3□ DOA Othe)C	lome 5 ☐ Reside		r (Specify)	
5	arthii eralo		27. Manner of Death		of Injury onth, Day Year)	28b. Time of	28c. Injury Work		28d. Describe h			
5	th.	Ş	1 ☑Natural 5 ☐ Pendir 2 ☐ Accident investi	9	ntn, Day Year)	Injury		res 2 □ No				
DIVISION	Atter dea octor	‡ice	3 ☐ Suicide 6 ☐ Could	ined 288. Plac	e of Injury - At he	ome, farm, stre	eet, factory, office		28f. Location (S		or or Rural I	Route Number,
É	after after Director	Certification:	4 Homicide	build	ting, etc. (Specif	y)			City or Tow	n, State)		
	spita nours neral		29a. Certifier 1 Certifyir	ıg Physician: To th	e best of my kno	wledge, death	occurred at the tim	ne, date and place	, and due to the c	ause(s) and mar	nner as stat	ted.
	To the Hospital or Attending Physicien: The law within 24 burus after death. To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2 or	edical	(Check only 2 Medical one)	Examiner: On the I	basis of examina nner stated.	tion and/or inv	estigation, in my op	inion, death occu	rred at the time, d	ate and place, a	nd due to t	he cause(s)
	To th To th	Me	29b. Signature and title of certifie	r			29c. License		2	9d. Date signed	(Month, D	ay, Year)
			1/6	MO			P18	548		Jul 2	, 200	06
	2		30. Name and address of person	who completed cau	ise of death (Iter	n 23a) (Tvpe. I					, , , ,	
			Richard Ericso	22 9	South 1	7120:0	Stroot	Baltin	20xe . 1	yn	2 120	
	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Signa	iture	market	,			7 1 2	-
	Registr		JUL 0	6 2005	1918	85 PG						

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Norman Anthony Bryant 10:00 a Jul 2, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Hospice of Baltimore (Gilchrist) **Baltimore** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□**∦** 2□F Director 217-68-5719 49 Jul 11, 1956 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fehow ?? ie marked other then "nature!", or iteme 23a or 28a-f ehov traumatic event, ibe Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1636 East Belvedere Ave. 21239 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 ☐ ★o If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ X0 ۵ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Davenport Painting Painter 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) Be 2 should be f and Mental b Jolin Bryant Delores Laws ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Important: if item 27 ie m eny injury or other traum Brenda Bryant Wife 1636 East Belvedere Avenue Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ &remation 3 ☐ Removal from State 07/07/06 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Sign for of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part1. Enter the disease, or complications that caused the death, shock, or hear failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Acquired immono deticiency Physician disease or condition resulting in death) ear /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and certificate be executed Due to (or as a consequence of): by Physician/Medical use as the attending I 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month signed by the al 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been si 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo July 2, 2006 no completed cause death (Item 23a) (Type, Print) N. Charles St. Bolts. Md Bm(6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Box 68760

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Please Type or Print in Black Indelible lnk

Donald H. Bosto		Γ. 1- For State	State	of Maryla	and / De	epartme Certifica	ent of	Health	n and		Hygi			2	nn	6 200
Physicia		Registrar 1. Decedent's Name (First,	Middle,Last)			Jertinoe		Doam				Date of Deat	g. No. h	hos	UC	3. Time of Death
Medical Examir		Donald		н.			Вс	ston	ı	Sr.	J.	#onth ⊔ly 4, 200	Day 06	Year		1430 hrs
1		4a. Facility Name (if not ins						b. City, To	wn, or L	ocation of D	eath		4c.	County of	Death	
		Johns Hopkins - E						Baltimo								
Funeral		5. Social Security Number	6. Sex		7. Age (In	yrs. last birth	nday)	If Under Months		If Under 24 Hours	Min			1	Foreiar	place (State or
Director	l	218-42-0268	1 X	M 2 F		62	Yrs.				I	August	13,	, 1943	Cou	ntry) Maryland
b		Usual Residence of Deceder 10a, State 10b, Co			100	City, Town	or Locati	on								10d. Inside City Limits
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e Mar or 28a	Director	6415 Danville	. A.r.					101. 210 0	212	2.4		'`			Coun	y :
r death with the Maryland or items 23a or 28a-f show must be notified at once.		11. Marital Status	a Avei	12. Was Dec	edent Ever	in IIS	13 Wa	s Deceden		anic Origin?	(Specif	v Yes or No		SA A Race -	Americ	an Indian, Black,
ath w	Funeral	1 Nover Married 2	Married	Armed Fo	orces?					Mexican, Pu				White,		an inglan, Dask,
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5-0036 fled within 7 Hygiene I other than	O	17. Father's Name (First, M	iddle, Last)						1	8.Mother's N			Maiden S	Surname)		
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5 21 should and Me	₽	19a. Informant's Name/Rela			ND.		_		,	and Number						Zip Code) 21015
, MD and 2 sho salth and em 27 is		20a. Method of Disposition	I UL.	SC		20b. Place o					•					Cown, State
Baltimore, permit. Pages 1 an Department of Hei Important: If ite		1 Burial 2 X Crer	nation 3	Removal fr		Bayvi	ory or oth	ner place)		ı J	uly 2006	7,			•	
tim trant:		4 Donation 5 Oth								45	2006					ity, MD.
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked offer than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		_21. Signature of Funeral Se	rvice Licens	see)			(C)	nnell	y Fi	ineral	Hon	ne Of	Dung	lalk,	P.A	• 24 222
Physician		23a. Part I. Enter the disea	se, or compl	ications that c	aused the	death. Do no	t enter th	ne mode of	dying, s	rs Poi	ac or res	spiratory arre	DUNC est, show	ck, or hear	MD.	21222 Approximate Interval
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30x 68760, death certificate by eattending physical for use as the burn	ian/Me	IF FEMALE: 23b. Was decedent pregnar	t in the	23c. If yes,		pregnancy								. Date of d		
68 certifi nding se as	cian	past 12 months?	it iii tiio	1 Live t	oirth nant at time	of 2		tal death her (Speci	3 _	Ectopic pr	egnancy			Month	D	ay Year
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eco he law ite has	Completed											perfo	rmed? 2 ✔ N		ath?	
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Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the an Ever arth. The return A flee this certificate has been signed by led in by the funeral director, page 2 should be detach	n: T	27. Manner of Death		28a. Date (Month	of Injury n, Day,Year)	28b.	Time of I			at Work?	- 1	. Describe	now i n ju	ry occurre	d	
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Divisior Hospital or Attend 24 hours after death Funeral Director:	ertification:	3 Suicide 6	Could not t	pe 28e. Plac	ce of Injury	- At home, fa	ırm, stree	et, factory,	office bu	ilding, etc.	28f	. Location (S		nd Number	or Rur	al Route Number, City
Dj spital ours s	Cert	4 Homicide	determined	(Specify)												
Division of Vital Records, P.O. Box 68760 within 24 hours after death certificate to the Hospital or Attending Physician: The law requires that the death certificate to the Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the but		(Cildon only		an: To the beach												
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		Lah	sl	0) //	1	•		J. U.IV				July	J, 2000		
17		30. Name and address of p Zabiullah Ali, M.D		completed cau stant Medio			1 Pen	n Street	. Baltir	nore, MD	21201	1				
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Registrar

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Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Robert Leroy Benway 1- For State Certificate of Death Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ July 1, 2006 Robert Leroy Benway, Jr. Medical Examine Year 1642 hrs 4b. City, Town, or Location of Death 4a Facility Name (if not institution, give street and number) 4c. County of Death N/A Johns Hopkins Bayview Medical Center Baltimore 5 Social Security Number Age (In yrs last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or **Funeral** Foreign Country)Maryland Months Hours Days 215 78 4197 Director $_{1}X_{M}$ 45 April 18,1961 2 Yrs Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits Maryland Baltimore s 23a or 28a-f show : e notified at once. Baltimore 1 Yes 2 X No 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 9813 Finsbury Road 21237 U.S. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, items a 1 Never Married 2X Married Armed Forces? White, etc. 2 X No Yes f Yes, Give Year Widowed Divorced Yes 2 X No specify: White permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygen Mental Hygen Inportant: If Item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. Specify ⋧ 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Maintenance Port Administration 12th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Robert Leroy Benway, Sr. Betty Murphy Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Linda Benway / wife 9813 Finsbury Road Baltimore, Maryland 21237 20a Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Glen Burnie, Maryland 7/10/2006 Glen Haven Mem. Park Donation 5 Other Specify 22. Name and Address of Facility Gonce Funeral Service, P.A 21. Sign Jore of Juneral Service L 4001 Ritchie Highway Baltimore, Maryland 21225 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Head Injuries Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and d. Physician/Medical ★ UNPENDED AMENDED by the attending physician ached for use as the burial X item#1,23a,27,28a-f,perME,g859,9/20/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown signed by t be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been a director, page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes ✓ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✓ Yes After 1 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d Describe how injury occurred 28c Injury at Work? Certification: Natural 1 X Yes 2 Pending 6/26/2006 Funeral Director: tely filled in by the 10:00 am subject fell 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pier 1, 2000 S. Clinton St. Baltimore City, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide (Specify) warehouse Homicide 29a Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b, Signature and title 29c License number OK pord O.C.M.E. July 8, 2006 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registra

Susan Hogan MD. 31. Date filed (Month,

Day, Year)

32. Registrar's Signature

			For State Registrar	State of Marylan		artment of He			giene	106	20961
			Decedent's Name (First, Middle, Las	t)				2. Date of Dea			3. Time of Death
	Physicia		Jellie	0	R	eooks		Month.	Day	Year	5:300 M
	/Medic		4a. Facility Name (If not institution, give	street and number)	L	4b. City, Town, or L	ocation of Death	yary	4c. Coun	ty of Death	100
	Examin	er	1700	76.	ect	1 ,				NIA	
			5. Social Security Number 6. Se				If Under 24 Hrs.	8. Date of Birt	h /	9 Birthi	place (State or Foreign
	Funeral Director			DM 20€F 95	Yrs.	Months Days	Hours Min.	Month, Da	y, Year)	Goul	ntry)
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	land	ı	10a. State 10b. County	10c. Cit	ty, Town or l	ocation					10d. Inside City Limits
	Mary feh	Ö	N/A	1	BA1	Timore					1. Pes 2 □ No
	1he 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntrv?
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	after death with the Maryland or items 23s or 28s-1 ehow intractions by marketing at	Funerai	11. Marital Status	12. Was Decedent Ever in U	S. 13	Was Decedent of Hist	nanic Origin? (Sr	pecify Yes or No		ice - Americ	
_	iten d	٤	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent of Hisp If Yes, specify Cuban,	, Mexican, Puerto	Rican, etc.)	Bla	ack, White,	etc.
2	hours after tural', or ite al Examina	β	3. Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ Yo	Specify:		Spec	ity: B/	ACK
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ם ס	Hyg Hyg other	Ö	17. Father's Name (First, Middle, Last)	//	,		18. Mother's Nam	e (First, Middle,	Maiden Suma		
	d be	00	Foddie Va.	1+			MAR	1//1	1.0	elles	
5	should be filed withir of Mental Hygiene. marked other than matic event, the M	ဂ္	19a. Informant's Name/Relationship (7	voe. Print)	19b. Mai	ling Address (Street an	nd Number or Ru	rai Route Numbe	r City or Town	State Zin	Code)
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. mportant: If tiem 27 is marked other than "natural", or items 23a or 28a-1 ehov ny injury or other traumatic event, the Medical Examinat must be notified at 2008.	}	4 Donation 5 Other (Specify 21. Signature, on Funeral Service Licen			22. Name and Address		7-06	13A/1	mor	ro nD,
מ	permit. Pages Department of Important: If i eny injury or once.		21. Signature on Furible 1 Service Electric	1-4	-	22. Name and Address	Funes	Al ton	12>	212	13
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			shock, or heart failure. List only	one cause on each line.	1. 50 110. 61	/ /	, such as cardiac	or respiratory at	1031,		Interval Between Onset and Death
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<u>-</u>	icate							1□ Yes	2 No	1 ☐ Yes	2 □ No
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UNISION	or A after Direct in by	Certification:	4 Homicide determined	building, etc. (Specif	y)	treet, ractory, office		City or Tow		Del Ol Mula	ir Abule Number,
_	plta ours eral filled		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	wledge dea	th occurred at the time	date and place	and due to the	cause(s) and m	120001 20 0	tated
	To the Hospital or Atlending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, paga	edical	(Check only one)	iner: On the basis of examina and manner stated.	ition and/or i	nvestigation, in my opin	nion, death occur	red at the time,	date and place	, and due to	o the cause(s)
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	0	-	30. Name and address of person who	completed cause of death (Item	n 23a) (Type	, Print)	(10		100/	0	
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		Registrar 1. Decedent's Name (First, Middle, Last)		Cer	uncate	e or Dean		2. Date of Dea	Reg. No.		3. Time of Death	
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Funeral		Social Security Number 6. Sex	7. Age (In yrs.	ast birthday)	If Under	1 Year If Unde	er 24 Hrs.	8. Date of Birti (Month, Day		9. Births	place (State or Foreign	
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ding Physicien: The June This certificate h funerel director, page		27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury		8c. Injury at / Work?		8d. Describe h	ow injur	y occurred		
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or At after of Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, tarm, stri y)	eet, factory	, office	21	City or Tow	n, State	d Number or Rura)	il Houte Number,	
To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompiletely filled in by the funeral director, page 2 should be detached for use as	a C	29a. Certifier TS Certifying Physi	cian: To the best of my kno	wledge, death	h occurr <i>e</i> d a	at the time, date a	and place, ar	nd due to the	cause(s)	and manner as s	tated.	
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To the To the COMP	M	29b. Signature and title of certifier				. License numbe	r			e signed (Month,		
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341		30. Name and address of person who con										
8		William Tanner 31. Date filed (Month-Day, Year)	, MD 11701		ngsto	on Rd.	#101	Ft. W	ash	ington	, Md.	
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State of Maryland / Department of Health and Mental Hygiene 🖊 🛛 🔝 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** KEITH V. BROWN July 2, 2006 3:36am /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APR. 22, 1958 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1∏ M 2□ F 219 62 7163 48 MD. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 √Yes 2 No Director BALTIMORE MD. N/A 10e, Street and Number 10f, Zip Code 10g, Citizen of What Country? 331 WESTSHIRE RD. 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? X□Yes 2□No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) 11TH PHARMACY TECHNICIAN NEIGHBOR CARE PH, Pages 1 and 2 should be filed and nent of Health and Mental Hygistric If Item 27 Ie marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CLARENCE BROWN NORA GRIFFIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVE. BALTO, BALTO, MD. 21213 KEITH V. BROWN JR(son) 3416 ELMORA 20b. Place of Disposition (Name of cemetery, crematory or other place) Ptte 2006 20a. Method of Disposition 20c. Location - City or Town, Slate 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ö OWINGS MILLS, MD. permit. Page Depertment of Importent: If any injury or once. GARRISON FOREST' VET CEM: Sonature of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate tntervat Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) asystole **Physician** /Medical Examiner Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a o Examine Attending Physician: The law requires thet the death certificate be executed DOWLL resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mounts?

1 Yes 2 No
9 Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Å Yes 2 □ No autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No within 24 hours after death.
To the Funerel Director: After thi
completely filled in by the funeral 27. Manner of Death 28b. Time of Certification: 28d. Describe how intury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L 1 A certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
21 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0058082 30. Name and address of serson who completed cause of death (Item 23a) Type, Print) 6535 N. Charles Gosnel 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 6 2006 Registrar

DHMH 17 Rev 1/2001

Baltimore.

.O. Box 68760,

Division of Vital Records, P.

		State of Maryland / Department of Hea Certificate of De	aath	giene 2 0 0 6	20964
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Funer Directo			Hours Min. 8. Date of Bir (Month, Date of Bir 8/16/	th ly, Yea <i>r)</i> 9. Birtl Co Mar	nplace (State or Foreign untry) yland
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larylar show	7	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 No
tha M 28e-f	Director	Md Baltimore Parkville 10e. Street and Number 10f. Zip Code		10g. Citizen of Whet Co	
h with		8820 Walther Blvd. 21234	4	USA	
r deat	Funeral	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.)	14. Race - Ame Black, White	
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dygier th		12 0 Process Che	ecker Mother's Name <i>(First, Middl</i> e,	Western	Electric
ld be f antal H ked of	To Be	Joseph Brzozowski	unkno	•	
Maryland d 2 should be file th and Mantal Hy 7 Is marked oth treumatic event	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end	er, City or Town, State, Z		
re, M stand 2 f Health item 27 I	1	Edward Brzozowski, Jr. 3218 Chesley			
S = 5 ≥ 5		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	71-page - 07874
altim nit. Pa artmen ortant: injury	ni i	4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest \ 21. Signature of Funeral Sgrvice Licensee 22. Name-and-Addiese of	V. A.//10/06 kff:iikFuneral H		ills, Md.
B Dep me			alk Ave. Bal		d. 21222
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.	uch as cardiac or respiratory a	rrest,	Approximate Interval Between
Physicia /Medica	_		1		Onset end Death
Examine		Immediate Cause (Final disease or condition resulting in death) e. Ventural talycar	nden	-	
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	edicai	that initiated events Pue to (or as a consequence of): resulting in death) Last	()		
Box 6i auth certific attending p	Physician/Me	d			
O. B.	sicia	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Pert I. 23b. Did f	tobacco use contribute	to the cause of death?
P. P. de by		(a)1)	1□	Yes 2□No 3□Pro	obably 4 dnknown
of Vital Records, Physicien: The law requires the this certificate has been signe real director, page 2 should be or	od by		24a. Was		Vere eutopsy findings
ecord aw require ts been sig	plet		репо	rmed? 6	veilable prior to ompletion of cause f death?
Il Rec Tha law ate has	Completed		101	Yes 2 No 1	□Yes 2☑No
f Vital Roysiclen: Thal	æ	exeminer?	3. Place of Death (Check only o		
on of ling Phys After this funeral dii	. To	27. Manner Death 28a. Date of Injury 28b. Time of 28c. Injury at	4 ☐ Nursing Home 5 ☐ Resident Application 28d. Describe h	dence 6 Other (Spec now injury occurred	ify)
rision trending I death. ctor: After	atio	2 ☐ Accident investigation M 1 ☐ Yes	2 □ No		
Division or Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (5 City or Tow	Street and Number or Ru vn, Stete)	ral Route Number,
DIVI To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, d	tate and place, and due to the	cause(s) and manner as	steted
n 24 h ne Fun e Fun bletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinio and manner stated.	n, death occurred et the time,	date and place, and due	to the cause(s)
Vithic to the congression	Ž	29b. Signature and title of certifier 29c. License nur	mber (0)	29d. Date signed (Month	, Day, Yeer)
O X	١	I A Summy	1442	+15/01	9
20		30 Name and addisess of person who completed cause dideath (Item 23a) (Type, Print) BNECE BURNER & WOOD Walture	Blul la	exorte on	d 21234
	tate	31. Date filed (Month, Day, Year) 32. Pigistrar's Signature		. —	. ,
Regis	trar	JUL 0 6 2006 Region & Sperile			

			1 - For State Registrar	State of Maryland		artmen tificat			nd M		giene) (006	20965
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	/Medi Examir	10.	4a. Facility Name (If not institution, University of Mary	and Medical (en	ter	Ba	ltim	Location of		,	4c. County of Death		
ξ.	Funeral Director		5. Social Security Number 1 6 214 16 8769 Usual Residence of Decedent	. Sex 7. Age (In yrs. las 1	t birthday) Yrs.	If Under Months	1 Year Days	If Under 2	Min.	8. Date of Birt (Month, Day JAN 9	h y, Year) ,1915	G94	place (State or Foreign ntry)
	show	ž	10a. State 10b. County	10c. City, 1			1005						10d. Inside City Limits 1 √Yes 2 □ No
	ith the Maryland or 28a-f show	Funeral Director	MD • N/	A	BA	LTIN 10f. Zip					10g. Citizen	of What Cou	
	s 23a o	erai D	2730 HARLEM		40.3			216	. 0 (0			USA	
5-0036	ours after de si', or itam Examiner	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No tf Yes, Give X Year or Dates:		Was Deced f Yes, sped 1 ☐ Yes		spanic Origin, Mexican, Specify:	in? (Spec Puerto F	cify Yes or No- Rican, etc.)		Race - Americ Black, White, ec <i>ity:</i> BI	
21215-0	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "naturs!', or Itams 23a or 28a-1 show avent, the Madiral Examiner must be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) Cotlege (1-4or 5+)	life. L	dent's Usua kind of wo DO NOT us	rk done d se retired)	urina most (of workin	ng		ATE H	
Maryland 2	e d fa	To Be Co	17. Father's Name (First, Middle, La EUGENE CHI	•				18. Mother		(First, Middle,			
	s 1 and f Health itam 27 other tr		19a. Informant's Name/Relationship FRED CHILDS/J 20a. Method of Disposition	AMES CHILDS		WES	STHI:	LLS F	RD.	Route Numbe BALTO ate	,MD.)
Baltimore,	permit. Page Depertment o importent: if any injury or once.		1 X Buriel 2 ☐ Cremation 3 4 ☐ Conation 5 ☐ Other (Special Service Lie	city) ARBU	TUS	MEM.	PK d Address	JULY s of Facility		2006 :			MD.
1760,	Physician //Medical sician and prival-transit	icai Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	Do not enter	412 er the mod	e of dying	, such as ca	ardiac or	ST. B.	A_TO	MD.	21213 Approximate Interval Between Onset and Death
P.O. Box 687	The law requires that the death certificate tte has been signed by the ettending physoage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		h 3 ⊟Ectopic pregnancy 5 ⊟ Other (specify)					23d. Date of delivery Month Day Year			
	quires that en signed b uld be det	۵	Part II. Other significant condition	s contributing to death but not resulting	ng in the ur	nderlying c	ause give	n in Part I.		23e. Did to			ne cause of death?
Vital Records,		Completed								24a. Was a autops perfor	SV	b. Were auto prior to coo death?	psy findings available mpletion of cause of 2 \square No
Vita	ysicien: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 npatient 2 ER	VOutpatien	2 0	Othe	-		(Check only or		D	
ivision of	ding Ph	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury 28 (Month, Day Year)	Bb. Time of Injury		8c. Injury Work	4 1 14012	21	e 5 Reside			y)
bivis	i i i i	edical Certification;	3 Suicide 6 Could no determine	building, etc. (Specify)						City or Town	n, State)		l Route Number,
V/	the Hospital hin 24 hours a the Funerel I mpletely filled	dica	29a. Certifier (Check only one) Certifying 2 Medicat Ex	Physicien: To the best of my knowle eminer: On the basis of examination and manner stated.	dge, death and/or inv	occurred estigation,	at the time in my opi	e, date and nion, death	place, ar occurre	nd due to the c d at the time, d	ause(s) and late and plac	manner as st e, and due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	mp			License		5417	1605	6 7/61	Zool	
	4		30. Name and address of person where the common state of the commo	o completed cause of death (Item 23	i ve w	Print)	f M	azula	and	1605			
	Sta Registr		31. Date filed (Month, Day, Year)	32. egistrar's Signature		of the	<i>y</i> ,		V • • • • • • • • • • • • • • • • • • •				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician ARV 12,25 pm une 24 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Randallstown Baltimore Northwest Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 200 F Yrs. 163-42-2485 Director 56 July 28, 1949 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural" ~ " any injury or other traumatic event." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Granite 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21163 U.S.A. 3623 Granite Road Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert W. Stevens M.K. Geraldine Geraghty 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3623 Granite Road Granite, Maryland 21163 Mr. Donald W. Bathgate, Sr. Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 06/27/2006 Ellicott City, MD 4 □ Donation 5 □ Other (Specify) St. John's Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Immediate Cause (Final disease or condition resulting in death) tructive dung disease Advanced Chronie **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P Examiner The law requires that the death certificate be executed ettending physicien and of for use as the burial-transit Due to (or as a consequence of); Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No been signed by the should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by (arcenong 1 Tes 2 No 3 ☐ Probably 4 ☐Unknown DEST 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificete 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 100 1 hpatient ပ္ 2 ER/Outpatient 3□ DOA : After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural s after de. •al Director: Alte 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D 5 4 2 8 8 29d. Date signed (Month, Day, Year)
TMME 24 19 2006 29b. Signature and title of certifier 30. Name and address of person who completed pause of death (Item 23a) (Type, Print) Korthwest fismula (outs 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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2006

CHESTIPH, WILL

	1	For State Registrar	ate of Maryland / D	epartment of H Certificate of L			ene2006	20968
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Physicia		Kirk Ox	SEAL CAR	eney		Month	Day Year	3:58 AM
/Medica		a. Facility Name (If not institution, give street			Location of Death		4c. County of Dea	<i>t</i> h
Examin		FUTURE CARE LOCA	KERP	Bali	HUR		0/.	H
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birt	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. Bir	thplace (State or Foreign
Director	-	220-60-9976 7ªM	50	Yrs.	8	JUNE 27	1956	nd Md
pus *	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
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28a-	Director	10e. Street and Number	Baltim	10f. Zip Code		10	g. Citizen of What C	ountry?
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natur	Completed	15. Decedent's Education (Specify only highest grade con	n 16a.	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	ation during most of work	ring	6b. Kind of Business	/Industry
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led w		12 + L 17 Father's Name (First, Middle, Last)	140	we Imbrons		e (First, Middle, M	- MIVA te	Contractor
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should nd Men of marke umatic	၉	19a Informant's Name/Relationship Type, F	Car Ney	. Mailing Address (Street		ral Route Number.	City or Town, State.	Zip Code)
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Health Health tem 27 other tr		20a. Method of Disposition	20b. Place of	Disposition (Name of y, crematory or other place			Oc. Location - City or	Town, State
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		21. Signature of Funeral Serv / Licensee	1(3 4 5 500	22. Name and Addres	ss of Facility 🧷 🗸	ATMAN	- Amis	THER HEME
Dearit. Deperting		Deray Sussia		5240 Rei	STENSTOWN	- Komo	Bolher	E, Rd 2/215
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OT VITAL IN Physician: The This certificate ral director, page	Be	25. Was case referred to medical examiner?	ital:	Oth	or /	th (Check only one		
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dlng h. After fune	tion	1 Patural 5 Pending 2 Accident Investigation	(Month, Day Year)	njury Wor	rk? Yes 2∐No		,,	
LIVISION for Attending after death. Director: Atte	flca	3 ☐ Suicide 6 ☐ Could not be	8e. Place of Injury - At home, fa	irm, street, factory, office		28f. Location (Str.	eet and Number or F	Rural Route Number,
DIV.	Certification:	4 Homicide	building, etc. (Specify)			City or Town,	State)	
DIVISION To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer			in. To the best of my knowledge On the basis of examination an					
the H in 24 the Fi iplete	Medicai	one)	and manner stated.					` '
To To Con	2	29b. Signature and title of certifier	,	29c. Licens	~~.		d. Date signed (Mon	nn, Day, Year)
7		- Lunu & fle	u	177	2731		Uly 5th	2006
5	1	30. Name and address of person with comple	eted cause of death (Item 23a)	(Type, Print)	Himma	2 MD	2/01/	8
Sta	te.	31. Date filed (Month, Day, Year)	32 Registrar's Signature	hoods ?	c v ir rur a	- 1 4)	2109	0
Registr		31. Date filed (Month, Day, Year)	July Sir Si	The same of the sa				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] [1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 40 STE 4, 2006 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba altimore 6. Sex Lours If Under 1 Year | If Under 24 Hrs. ville Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12M 20F 213-54-077 Months Days Hours Min Yrs. Director MAR Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be cotified at Director 1 ☐ Yes 2 No MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Items 23a SPRING Be Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygene. Importent: If item 27 is marked other than "natural" ...". any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 20 No Specify: 3 Widowed 4 Divorced BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MERADE ASSISTANI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A. dress (Street and Number or Rural Route Number, City or Town, State, Zip Code) 390 20b. Place of Disposition (Name of cemetery, crematory or other place) LIKAIL 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State RBUTUS CEME 4 ☐ Donation S ☐ Other (Specify) 21. Signature of Funeral Service Licens 2140 22. Name and Address of Facility North Fulton Avehue 21217 Joseph H. Brown, Jr. Funeral Home 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dus to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit ate has been signed by the attending physicien and page 2 should be deteched for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 2 No 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one Hospital: Other: 1 Yes 2 6 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) this 28b. Time of Injury 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and lace, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

31

Date filed (Month, Day,

0 6 2006

32. Pagistrar's Signature

			1 - For State Registrar	State of Maryla		artment of F		and Mei		jiene eg. No.	106	20970
	Physici /Medi		11.00	lifford				2.	Date of Dea Month D 7	th Day	Year 2006	3. Time of Death 8:45 P M
	Examir Funeral Director	ner	5. Social Security Number 6. Sec. 192–18–3740	ounty Ho		If Under 1 Year Months Days		mbia	Date of Birth (Month, Day IAR 18		Coun	lace (State or Foreign
	within 72 hours after death with the Maryland and and I have 'naturel', or Items 23a or 28e-f show then 'naturel', or Items 23a or 28e-f show item Majical Evantier must be rivillard at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County WV Jeffer 10e. Street and Number 35 Mountain To	son	ity, Town or Lo	Ha 10f. Zip Code 25	5425	Ferr	1		What Coun	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla if Heelth and Mental Hygiene. If Heelth and Mental Hygiene thems 23a or 28e-1 show them 27 I marked other then "naturel", or Items 23a or 28e-1 show other treumetic event, the Medical Everginal format by multiple at the configuration of the configuration	Completed by Fun	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edi (Specify only highest grace) Elementary/Secondary (0-12)	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	16a. Deced	Was Decedent of H Yes, specify Cubit I Yes 2 XNo dent's Usual Occup kind of work done DO NOT use retired	Specify:				Business/Ind	ite
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ď	Page nent c ant: If ury or		Kevin M. Clifford 20a. Method of Disposition 1 Burial 2 XCremation 3 1 '4 Donation 5 Other (Specify,	Removal from State Me	2054 Place of Dispo cemetery, cren etro Cre	Bank Str sition (Name of natory or other place ematory,	reet Inc	Baltin Date 7/5/06	nore, l	MD 212.	31 - City or Too imore,	wn, State
Ball	permit. Pa Departmer Importent any injury		-	zegorchik 22. Name and Address of Facility Crentage 29 Frederick Road 299 Frederick Road					Baltin	nore, 1	of M 1D 212	D, Inc. 228 Approximate
	cate be executed /Medical Examiner the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(. /	Quenou d):	ion						Interval Between Onset and Death day
. Box 6	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of o	al death 3 □	Ectopic pregnancy Other (specify)					ite of deliver	ry Day Year
Records, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	ntributing to death but not res	sulting in the un	derlying cause give	en in Part I.		23e. Did tob			e cause of death?
<u> </u>	The ate h page	e Completed	25. Was case referred to medical							ed? No	Were autop prior to com death? 1 ☐ Yes 2	sy findings available apletion of cause of
	fing Phys n. After this i funeral dir	To B	examiner? 1 Yes 2 No 27. Manner of Death 1-Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	er: 4 □ Nurs	sing Home 28d.		nce 6 ⊡Oth w injury occur		
-	7 2 2 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	fy)				City or Town,	State)		Route Number,
	To the Hospital of within 24 hours af To the Funerel D completely filled to	Medical	29a. Certifier 1 ☐ Certifying Phy. (Check only one) 2 ☐ Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the timestigation, in my op	pinion, death	l place, and on occurred at	the time, da	use(s) and ma te and place, d. Date signe	and due to t	the cause(s)
,	- 3 + 8		30 Name and address of person who co	m D	n 23a\ /Tree - 5	Do	053	709		7	1 1 0 6	wy, 1941)
	V Sta Registr		31. Date filed (Month, Day, Year)	14300 G	all ant-		lane	STE	# 2	_1 0 %	Bowic	MD

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

•	F	- Fcr State Registrar		Cei	rtificate of	Death	,,,	Reg No.	200	6 2097
Physician Medical Examine	//	1. Decedent's Name (First, Midd					Date of De Month	Day	Year	3 Time of Death 1342 hrs
Medical Examine		Phyllis C. Conaw 4a Facility Name (if not institution		lumber)	14	b. City, Town, or Location	July 2, 2		County of Death	
		703 Dolphin Street 1s	-	,		Baltimore City			,	
Funeral		5 Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)			Birth(MM/D	D/YYYY) 9 Birt Foreig	
Director	L	212-44-1179	1 M 2 X F		59 Yrs.	Months Days Hou		/14/19		untry) MID
s'u		Usual Residence of Decedent 10a State 10b. County		10c. City,	Town or Location	on				10d. Inside City Limits
id Fe. se		MD			Baltimore					1 XX Yes 2 No
farylar 8a-f s at on	Director	MD 10e. Street and Number				10f. Zip Code		10g. Citize	en of What Cour	ntry?
death with the Maryland or items 23a or 28a-f show any must be notified at once.	5	703 Dolphin St.	Apt. 1			21217		USA		
er death with t	<u> </u>	11. Marital Status 1 Never Married 2 M	12. Was De	cedent Ever in U.		Decedent of Hispanic O s, specify Cuban, Mexica			4. Race - Americ White, etc.	can Indian, Black,
			1 Yes	2 X No	1	Yes 2 x No specif	Sec.		Specify Bla	ols.
urs aft tural' amine	3	15. Decedent's Education (Spe	or Dates.		16a. Decedent	s Usual Occupation (Giv	e kind of work done		nd of Business/I	
6 72 ho ral Ex	Collipleted	Elementary/Secondary (0-12)	College ((1-4 or 5+)	during mo	st of working life DO NO	T use retired)			
within giene Ber tha		12 17. Father's Name (First, Middle	1 4)		Jani				udsville	
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21215 rould be file of Mental H of Mental H ite event, I	2	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address (Street and Nu	res Williams umber or Rural Route No	ımber, City	or Town, State,	Zıp Code)
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene n 27 is marked other than aumatic event, the Medica	1	Caroyln William	s/Daughter		1807	N. Caroline S	t Baltimore	м-212		
		20a Method of Disposition 1 Burial 2 X Cremation	n 3 Removal f		Place of Disposit crematory or oth	ion (Name of cemetery, er place)	Date	7 20c. Lo	ocation - City or	Town, State
Baltimore, bernit Pages I ar Department of Hee Important: If iter injury or other tr	-	4 Donation 5 Other S		<u>M</u>	etro Crem	atory ame an Address of Facil	July 6,2006	L Ca	atonsville	- MD
Balt permit Depart Import injury		21. Signature of Funeral Service	Licensee							•
Physician	5	23a. Part I. Enter the disease, or	complications that	caused the death	Do not enter the	Lie Funeral Ho e mode of dying, such as	me/ 638 N.Giln cardiac or respiratory a	nor Bal rrest, shock	Ltimore,MI k, or heart	Approximate Interval
/Medical Examiner	ā	failure. List only one cause Immediate Cause (Final disease	A 41 1-	erotic Cardiov	ascular Dise	ase Complicated b	y Hyperthermia			Between Onset and Death
Aanmer	1	or condition resulting in death)	Due to (or as	a consequence of	f):					
3	<u>.</u>	Sequentially list conditions, if any, leading to immediate		a consequence of	f):					
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w requires that the death certificate be executed is been signed by the attending physician and should be detached for use as the burial - transit	25	UNPENDED	AMENDED							
8760, ificate be up physici		IF FEMALE [.] 23b. Was decedent pregnant in the	23c If yes,	outcome of pregr		2 5			Date of delivery	
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Bo he deat the at the at red for	Finysicial	1 Yes 2 No 9 V Uni	9 Unkr							
that the ned by detacl	5	Part II. Other significant condit	ions contributing t	to death but not re	esulting in the ur	derlying cause given in f		-		he cause of death?
ds, l	Completed		-				24a Was			opsy findings available
COr law re has b	희							ormed?		ompletion of cause of
Vital Reco ysician: The law his certificate has director, page 2 s		25. Was case referred to medica	1			26 Place of Deat	1 Yes	2 V No	1 Ye	2 No
Vital hysician this certi	٦ I	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	Othor	Nursing Home 5	Residence	ce 6 🗸 Other:	Scene
Division of Vital Records, P.O. ra after death al or Attending Physician: The law requires that the all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach		27. Manner of Death	28a. Date	e of Injury h, Day,Year) D:	28b. Time of In		Subject ex			
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Division or spital or Attending I nours after death noral Director: After filled in by the funer		dete	ld not be	ce of Injury - At ho residence	ome, farm, street	, factory, office building,	or Town,	State)	Number or Rur , Baltimbre,	al Route Number, City
Hospit 4 hour Funers ely fill	3	4 Homicide 29a Certifier 1 Certifying P	· · · · · · · · · · · · · · · · · · ·		ge, death occurre	ed at the time, date and p				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit.	<u> </u>			of examination ar		on, in my opinion, death o				
- » - » S	ž	29b. Signature and title of certifie		Λ n		29c License numbe	er		ate signed (Mon	th, Day, Year)
		Palullio	tol	lehan		O.C.M.E.		July 3	3, 2006	
1		 Name and address of person Patricia Aronica-Polla 	· ·	use of death (Item tant Medical E		111 Penn Street, B	Baltimore MD 2120	01		
Stat	(a)	31. Date filed (Month, Day, Year)		legistrar's Signatu				- 1		
Registra	**	1111 0 6 20		Le Le	sperke	•				

Amend 1tem 20 per doc 280 / 7-6-00 vt State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Month **Physician** July 1
4b. City, Town, or Location of Death 1, 5:25 PM 2006 /Medical Marjorie Talbert Clower 4a Fecility Name (If not institution, give street end number, 4c. County of Death Examiner Baltimore 20 Lovett Court Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 20, 1915 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Days Hours Months Yrs. 90 Director 411-09-0754 Mississippi Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland artment of Health and Mentel Hygiene.

ortant: If Item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, it is Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Timonium MD Baltimore Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 United States 20 Lovett Court 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 □ Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Insurance 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Talbert Olive Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Lovett Court, Timonium, MD 21093 Hugh Clower, Jr. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens 7/05/06 Timonium, Maryland 22. Name and Address of Facility Brian T. Chisholm Funeral Services of 21. Signature of Funeral Service Licensee M01113 Dularey Valley, P.A. 200 Padonia Rd., Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical (aspiration) week Preymonia Examiner Due to (or as a consequence of) Physician/Medical Examine 100r 14 ne concer law requires that the deeth certificate be executed ettending physician and for use as the burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ been si 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? after deeth.

I Director: After this certificate has bed in by the funeral director, page 2 to 2N No 1 ☐ Yes 2 No 1 🗆 Yes To the Hospital or Attanding Physician: within 24 hours after deeth.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Wes case referred to medical examiner? B 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) ٩ 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 12 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D20604 7/3/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bergind; #450; 10755 Fells Rd, Lutterville, Ld 21093 Richard A. 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State Registrar **DHMH 16 Rev 6/95**

			1 - For State Registrar	State of Marylan		artment of F			giene Reg. No.	006	20973
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Dav	Year	3. Time of Death
	/Medic		Roy Lee		bers,				3, 2006		8:03PM M
	Examin	ier	4a. Facility Name (If not institution, give s	,		4b. City, Town, o	r Location of Dea	th		ty of Death	orge's
	Funeral		Southern Marylar 5. Social Security Number 6. Sex		last birthday)	If Under 1 Year			h	,	place (State or Foreign
	Director		409-16-1260	(M 2□F 86	Yrs.	Months Days	Hours Min	Dec. 2	2,1919	Cou	ntry) nessee
	D		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	postion					0d. Inside City Limits
	/anyla	ō	Maryland Prince Ge		•	shington					1 ☐ Yes ŽXNo
	28a-	Director	10e. Street and Number	orge 5	OIL Was	10f. Zip Code			10g. Citizen of	What Cour	
	death with the Maryland ms 23a or 28a-f ehow f must be notified at	io ie	7301 Webster Lane			20744			U.S.		, .
	ems deat	by Funeral	11. Marital Status	2. Was Decedent Ever in U. Armed Forces?		Was Decedent of H	lispanic Origin? (S	Specify Yes or No-	14. Ra	ce - Americ	can Indian,
9	or it	y F.	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐XYes 2 ☐ No 19. If Yes, Give	44-	1 ☐ Yes 2 ဩrNo	Specify:		Speci		
21215-0036	hour tural		15. Decedent's Educ	Year or Dates: 19	1	dent's Usual Occup	ation		16b. Kind of I		
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7	giene giene	Com	12th		Eng	ineer			Survey	ing E	luipment
and	be filed within 72 hours after death with the Marylan tall Hygiene. All Hygiene. All the Medical Examination must be notified at	Be	17. Father's Name (First, Middle, Last)					me <i>(First, Middl</i> e, cie Pirkl		me)	
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M	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 ie marked eny injury or other traumatic evonce.		19a. Informant's Name/Relationship (Type Caroline Bowman (ng Address <i>(Street)</i> Lake Cha					
<u>.</u>	t Heal tem		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	T., 1.	, Date ,	20c. Location		
Ē,	Page not o not: #		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Ma	ryland	veterans		2006	Chelte	enham	, Maryland
	permit. Departir importe eny inju		21. Signature of Funeral Service License			. Name and Addres					
מ	80.59		MISTOR	L 170015						linto	n, MD20735
	Physician /Medical Examiner		23a. Par1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence)	uence of):	GENIC	CAH	Co respiratory and	MA		Approximate Interval Between Onset and Death
	sit a	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	uence of):						
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Vital	sertific sector,	Be	25. Was case referred to medical examiner?			la		ath (Check only or			
5	this c	10	1 ☐ Yes 2 No	28a. Date of Injury	ER/Outpatien 28b. Time of		4 Nursing F	lome 5 ☐ Reside)
5	After fune	tion	Natural 5 Pending	(Month, Day Year)	Injury	Work	γαι ⟨? Yes 2 □ No	28d. Describe h	ow injury occur	төа	
VISION	r deal	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	me, farm, stre			28f. Location (Si	reet and Numi	ber or Rura	Route Number,
5	rei Dir	Certification:		building, etc. (Specify				City or Town			
	to the nozepher or detending rivercent. The available to the Function of the Completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2.	Medicai	29a. Certifier (Check only one) Certifying Physi	cian: To the best of my known or: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the time restigation, in my op	ne, date and place pinion, death occu	a, and due to the curred at the time, d	ause(s) and m ate and place,	anner as st and due to	ated. the cause(s)
	withir To th comp	Me	29b. Signature and the or certifier	D		29cr icense	number	2	9d. Date sign	d (Month, I	Day, Year)
) WW M	7		INS	3885		1/0	1 13	2006
P	オ \			npleted cause of death (Item M AMW 755)	23a) (Type, I	RA715	Ross #	1307 C	inton	ND	20735
	Sta Registr		31. Date filed (Month, Day, Year) 6 200	32. Registrar's Signar	ture	and a					

06-04654 Please Type or Print in Black Indelible Ink Shirley Diane Cornelson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) Shirley D. Cornelison Physician/ Shirley Diane Cornelson Medical Examiner 4a Facility Name (if not institution, give street and number) 18507 Queen Anne Road Upper Marlboro 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 214 28 3888 Director м ХХ г 74 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County ì or 28a-f show PA Fulton Warfordsburg notified at once. Director 10e. Street and Number 10f. Zip Code 286 Deerlick Lane 17267 23a 11 Marital Status 12. Was Decedent Ever in U.S Funera Armed Forces? 1 Never Married 2 XX Married 2 XX No Yes If Yes, Give Year Divorced 3 Widowed "natural". ģ or Dates 15. Decedent's Education (Specify only highest grade completed) Completed AD 21215-0036 2 should be filed within 72 hor h and Mental Hygiene 27 is marked other than "na Elementary/Secondary (0-12) College (1-4 or 5+ Pages 1 and 2 should be filed within 721 ment of Health and Mental Hygiene tant: If item 27 is marked other than or other traumatic event, the Medical or other traumatic event, the Medical 11 Bus Driver 17. Father's Name (First, Middle, Last) bert Miller Be 19a Informant's Name/Polationship (Type, Print) ဥ Edgar E. Cornelson (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 XXCremation 3 Removal from State Important: injury or otl Other Specify permit 21. SI Physician /Medical failure List only one cause on each line a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed and Physician/Medical X AMENDED attending physician a UNPENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy Was decedent pregnant in the Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown g Unknown o ģ Diabetes

Rea No 2. Date of Death Month July 3, 2006 0547 hrs 4b. City, Town, or Location of Death 4c. County of Death Prince George's If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9 Birthplace (State or Foreign Hours Country) MD 31 10d. Inside City Limits 1 Yes 2 v 10g Citizen of What Country? United States Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Yes XX No specify. Specify White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry School School Prince George Co. 18 Mother's Name (First, Middle, Maiden Surname) Rose M. Shives 9b. Mailing Address (Street and Number or Rural Route Number, City or Town State Zip Code) 286 Deerlick Lane, Warfordsburg, Pa 17267 20c Location - City or Town, State Lee Crematory July 5, 2006 Clinton, MD 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death item#1,perME,item#17,19a,perFH,G857,7/12/06 TT 23d Date of delivery 3 Ectopic pregnancy Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, P. Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 V No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Hospital: 1 Other₄ Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other Scene 1 V Yes . Manner of Death 28a Date of Injury (Month, Day, Year) 28c. Injury at Work 28d Describe how injury occurred 28b. Time of Injury the Hospital or Attending Certification; 1 V Natural 1 Yes 2 No 5 Pending 24 hours after death. Funeral Director: 2 Accident 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated 29b. Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year) O.C.M.E. July 4, 2006 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene?

		-	For State Registrar		State of	Marylan		artment of H tificate of L		Mental Hygi	iene2006	20975
	Dhusiai		Decedent's Name	(First, Middle, Last)		-			2. Date of Death Month	h Day, Year	3. Time of Death
	Physici: /Medic	al .	ROSA U		VN					07	04 2000	544
	Examin	er	4a. Facility Name (If	not institution, give	AUE				, Mo		4c. County of Dea	lA
	Funeral Director		5. Social Security Nu 223 • 54 •	7854 10	x □M 2DXF	. Age (In yrs. I	last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 9. Bi	rthplace (State or Foreign ountry)
	land		Usuel Residence of I 10a. State	10b. County		10c. City	y, Town or Lo	cation				10d. Inside City Limits
	Mary Ind	ţ	MD	NA			Balt	more				1 Mayes 2 □ No
	or 28g	Director	10e. Street and Num		4-1-			10f. Zip Code	1001	10	0g. Citizen of What C	
	ath w			rizona/			2 10		1206	Sanati Van an Na	14. Race - Am	
21215-0036	d within 72 hours after death with the Maryland Jiene. I then "natural", or items 23s or 28s-f ehow the Medical Evantilational be notified at	by Funeral	11. Marital Status 1 □ Never Marrie 3 □ Widowed		12. Was Deced Armed Ford 1 Tes, Give Year or Da	es? ∑∕No		Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (in, Mexican, Puei	rto Rican, etc.)	Black, Wh	
50	72 h	etec		15. Decedent's Edit fy only highest grad			(Give	dent's Usual Occup- kind of work done o	during most of wo		16b. Kind of Business	s/Industry
121	within then then	Completed	Elementary/Secon		College (1-	4or 5+)		Beautic	ian .		Cosmet	ologu
	T ty	Be Co	17. Father's Name (I.		18. Mother's Na	me (First, Middle, A		
ylar		ToB	Kit W.	illiams					Mary	Blick		
Maryland	nd 2 suith ar 27 io		Shelia A	ma/Relationship (7 NO EVS OV	12	ahter	19b. Mailir	ng Address (Street a	and Number of Fl Alent	iural Route Number.	City or Town, State, MOND MI	Zip Code) 21206
ore,	00			Cremation 3 🗆	Removal from S	20b. P	emetery, crei	sition (Name of matory or other place		Date	20c. Location - City o	
Baltimore,	permit. Page Depertment Important: I eny injury o		21. Signature of Fur	5 Other (Specify,	600	1363	- 1	Name and Address	ss of acility Overne F	juneral Sel	Wicas -	2
	au = • u		23a, Part1, Enter th	e disease, or comp				er the mode of dvin		Baltimby ac or respiratory arre		Approximate
	Physician		shock, or hear Immediate Cause (I disease or condition resulting in death)	t failure. List only o Final	a. end 4	th CV	IA					Interval Between Onset and Death
	/Medical Examiner		rooding in douting	ſ	Due to (d	ras a conseq	uence of):					
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	acuted ind transit	Examin	cause. Enter Under Cause (Disease or i that initiated events resulting in death) L		c							
8760,	icate be executed physicien and s the burial-transit	a E	rosoning in dodiny c		Due to (c	r as a conseq	uence or):					
687	ificate g phys as the	edicai			d						1	
O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 (1 ☐ Yes 2 ☑ 9 ☐ Unknown	months?		th 2 ☐ Feta int at time of d	Ideath 3[Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
a	quires that n signed b uld be deta	ρ	Part II. Other signifi	icant conditions co	ontributing to dea	ath but not res	ulting in the u	nderlying cause giv	en in Part I.			to the cause of death?
l Records,		Completed								24a. Was ar autops perform 1 🗆 Yes 2	y prior to neg? death?	utopsy findings available completion of cause of s 2 No
Vital	Physician: The this certificate ral director, pag	Be (25. Was case referr examiner?	-	Hoonital:			104		eath Check only on	9)	
ō	Phys	1.	1 ☐ Yes 2 S	NO	28a, Date o	f Injury	ER/Outpatier 28b. Time o		4 Linuising		ence 6 Other (Sp ow injury occurred	ecify)
lon	Attending Pt ir death. ector: After th by the funeral	ation	1 ØNatural 2 ☐ Accident	5 Pending investigation	(Month	n, Day Year)	Injury	Wor	k? Yes 2 ∐No			
Division	or Attendii after death. Director: A	Certification:	3 Suicide 4 Homicide	6 Could not be determined	200. Place	of Injury - At ho g, etc. (Specif	ome, farm, st	reet, factory, office		28f. Location (Sti City or Town	reet and Number or F n, State)	Bural Route Number,
	To the Hospital or Attentwithin 24 hours after deation to the Funaral Director: completely filled in by the	edical C	29a. Certifier (Check only one)			sis of examina					ause(s) and manner a ate and place, and du	
	Within Jo the	Me	29b. Signature and	title of certifier				29c. Licens	e number	29	9d. Date signed (Mor	nth, Day, Year)
	0		► WL	nd Kl				D31	291		7/6/06	
1	<u> </u>		30. Name and addre	ess of person who	completed cause	of death (Item	n 23a) (Type, UEN B	Print) LVD, P.O.E	B., SuITE	208A, I	BALTO, MO	21239
	Sta Regist	ate rar	31. Date filed (Mont	th, Day, Year)	06 32.4	ngistrar's Signa	ature A	medi		,		21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death . Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year **Physician** D1445 JULY 7:19 2006 02 /Medical **Examiner** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST CTR RANDALISTOWN, MD BAUTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 20 F Days Hours Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Importent: If Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event; the Medical Examinat must be profiled at angle. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BATIMORE 12 Yes 2 □ No MD. To Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 454 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Yes. Give Specify 3 Widowed 4 □ Divorced Specify: BLACK Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ムメ 17. Father's Name (First, Middle, Last) SAMUEL CAMPBELL 19a. Informant's Name/Relationship (Type, Print) (SISTER) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2114 WESTWOOD SUTTON Date 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of Facility PHULP A. WENTER BAD Fut. Series 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Er er the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 12431 E. CLIVER ST. BALTO. MD. 21213 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCUL Physician ACCIDENT /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the attanding physicien and hed for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by BESITY 1 ☐ Yes 2 ☐ No 3 Probably DISORDER SEIZURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA neral Director: After th filled in by the funeral 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month) Day, Year) 053910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

MAHESHWARI

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

NORTHWEST

MD

2006

32. Registrar's Signature

MOSPITAL, LANDALISTOWN, MD

State of Maryland / Department of Health and Mental Hygiene') Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month Day Physician Helen Dawson June 27, 2006 12:31 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3912 Dorchester Road Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9 Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🛛 F Yrs. Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f shov nutified at 1 XYes 2 No Directo Marylana 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or any injury or other traumatic avent, It a Medical Examinal must ke 212 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Š 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be မ 19a. Informant's Name/Relationship (Type, Print) Friend) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐Donation 5 ☐ Other (Specify) arme 21. Signature of Funeral Service/License 22. Name and Address of Facility any ir Joseph Li Russ! era 23a. Parti Enter the disease, or complications that cabes shock, or heart faillire. List only one cause on each cabeed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ancel alos Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): burial-Box 68760, physicien Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 □ Yes 2 🗷 No Division of Vital Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 🗌 No 1 Yes 2 No 1 🗆 Yes 25. Was case referred to medical examinar?

1 Pres 2 No To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 27. Manner death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After 1 Territural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29c. License number 29d. Date signed (Month, Dey, Year) D26748 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IBEROI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

			1 - For State Registrar	State of M	arylar		artmen rtificat			nd Me		giene () Reg. No.	06	2097	18
	Physici /Medio		1. Decedent's Name (First, Middle, La	Deor.							2. Date of Dea Month	Day	Year	3. Time of Dea	М
	Examir		4a. Facility Name (If not institution, given	re street and number)	cen				Location of	Death		4c. Coun	ty of Death		
	Funeral Director		5. Social Security Number 6. S			last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	B. Date of Birt (Month, Da Dec 7,	h	9. Birtho	lace (State or Fo	reign
	Maryland f ehow	or	10a. State 10b. County	I/A	10c. Cit	ty, Town or Lo	ocation	Bal	timore				1	0d. Inside City Li 1 Yes 2	
	with the !	Direct	10e. Street and Number 2312 Koko Lane		1		10f. Zip	Code	21216	6		10g. Citizen of	What Cour	-	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Depertment of Health and Mental Hyglene. Important: if Item 27 ie marked other then "netural", or Iteme 23a or 28a-f ehow mithorial transfer and the modified a page. Page 1 in the Medical Examinar must be notified a page.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 M Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 If If Yes, Give Year or Dates:	No 19	12	Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No- ican, etc.)	- 14. Ra Bl	ace - Amend ack, White, ify: B		
21215-0036	within 72 ho jiene. r then "netur the Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	5+)	16a. Dece (Give life.	kind of wo DO NOT u	rk done d se retired)	uring most		g	16b. Kind of United S		dustry Ostal Service)
Maryland 2	12 should be filed within n and Mental Hygiene. 7 le marked other then "raumatic event, the Med	To Be C	17. Father's Name (First, Middle, Last Edgar	Dearing					18. Mother	's Name		Maiden Suma cy Dearing			
	1 and 2 sho Health and N Iem 27 Ie ma other trauma		19a. Informant's Name/Relationship Cecil Dearing	Type, Print)		19b. Mailii 42	ng Address 168 Rok	(Street a	nd Number pad Balt	or Rural imore,	Route Number Maryland	or, City or Town 21229	n, State, Zip	Code)	
Baltimore,	Pages 1 and ment of He ant: If Item		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Speci			Place of Dispo cemetery, crea arrison Fo	natory or o	ther place		ry 0	7/05/06	20c. Location	· City or To vings Mil		
Balti	permit. Page Depertment of Important: If eny injury or once.		21. Signature of Futherny Service Live	ES	2	22	2. Name an Es 13	d Addres tep Br	s of Facility others F aw Plac	uneral ce Balti	Service, more, Md	P. A. 21217			
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or one shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Line, tindefining Cause (Disease or injury)	a. Due to (or as	a conseq	uence of):	er the mod	e of dying	, such as c	ardiac or	respiratory ar	rest,		Approximate Interval Betweer Onset and Deati	
68760,	death certificate be executed e attending physician and confician and conficial transition of for use as the burial-transition.	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Plue to (or as		quence of):	c =	3	or	H-m.	Lun	1			
P.O. Box 6	that the death certif hed by the attending detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	al death 3[Ectopic pr Other (sp						ate of delive	ny Day Year	
rds, P	w requires that been signed b should be deta	ğ	Part II. Other significant conditions	contributing to death b	out not res	sulting in the u	nderlying c	ause give	n in Part I.			_		e cause of death ably 4 □Unkn	
Il Records,	Physician: The law requires that the this certificete has been signed by the rail director, page 2 should be detach	Completed								_	24a. Was autop perfor 1 Yes	rmed?	Were auto prior to cor death? 1 \(\subseteq \text{Yes}	psy findings avail npletion of cause 2 No	able of
Vital	cian sertific ector	Be	25. Was case referred to medical examiner?	Hamital			-	1 00			Check only o				
	fe fe	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		ER/Outpatier 28b. Time o Injury		8c. Injury Work	r: 4 □ Nurs at ? 'es 2 □ N	28		lence 6 Ot		/)	
Division	at or Attending s after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	e Olean of Ini	iury - At h	ome, farm, str	eet, factory	, office		28	8f. Location (S City or Tow		ber or Rura	l Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	nysician: To the best miner: On the basis o and manner st	f examina	owledge, deat ation and/or in	n occurred vestigation	at the tim	e, date and inion, death	place, ar occurred	nd due to the o	cause(s) and made	nanner as st , and due to	ated. the cause(s)	
	To the To the comp	Ř	29b. Signature and title of certifier				290	. License	number			29d. Date sign			
	/		30. Name and addreg of person who		– death (Iter	п 23а) (Туре,	Print)	02	90	8-5		June	28	200	<u></u>
	5		31. Date filed (Month, Day, Year)	32 Paniete	S Sign	3 (O)	200	Cou	· -+	Re	60	2	1133		- 1
	Sta Registi		.1UL 0 6 20	06 literas		ture	W.								

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2006 **Physician** Month July Irene Rodgers Deuterman 5:10 pm^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Wesley Home Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 24,1907 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛶 F 98 Yrs Virginia Director 577-18-9181 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits 28a-f show is marked other than "natural", or Iteme 23a or 28a-f ebov eumatic event, the Madical Examinar must be notified at Maryland N/A Baltimore Yes 2 No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2211 W. Rogers Ave. 21 209 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No tf Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: ۵ 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cottege (1-4or 5+) Elementary/Secondary (0-12) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rodgers Charles Cecil Ollie Riggle Л. 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2;
Department of Health ar
Importent: If Item 27 is
any Injury or other treu 3 Forest Ridge Court Donald Deuterman / Son Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stonewall Mem. Gardens 7/7/06 Manassas, Virginia 21. Signature of Fur eral Service Live 22. Name and Address of Facility 1050 York Ruck Towson Funeral Home, Inc. Towson,Md.21204 23a. Part1. Enter the disease, or shock, or heart failure. List eations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, no cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** DYSRHYTHMIA ACUTE /Medical Examiner CARDIOVASCULAR ARTERIOSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physicien and d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medicai 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA -1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown page 2 should peed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? ormed? 2 X No certificete 1 ☐ Yes 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? Certification: 28b. Time of 28d. Describe how intury occurred To the Hospitel or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number Coly who completed se of reath (Item 23a) (Type, Print) - 2211 W. ROGERS AVE - BALTIMORE MD ROBY, MD E.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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2121

Baltimore, Maryland

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of Vital

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12006

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 8 per fth 8577-6-06 vt

Amend Items 23a, Pt 1,11,25,27,28a-f per ME, C857,07/13/06dhb

Certificate of Death

Reg. No.

Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ULY Day, Physician 2006 8:11P Mollie Helen Doyle /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) Center 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 922 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Director 214-20-3396 84 March 13 1972 MD Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. fnside City Limits Director 1 ☐ Yes 2 ☐ No MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1138 Greenway Rd. 21030 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ Specify: 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor n/a Bendix 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Burnham Florence Haines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Heelth at Importent: If item 27 is eny injury or other trau once. William E. Fitch/cousin 1138 Greenway Rd., Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donatjon 5 ☐ Other (Specify) 7/10/06 Dulaney Valley Memorial Gardens Timonium, MD 1. Siz Bryan W. Clar 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Clary 23a. Part 1. Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line. sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hine. Complications of cardiac Catheterization

REPIAL INFORMATION and Central Line Placement Approximate Interval Between Onset and Death 72 **hours** Immediate Cause (Final disease of condition resulting in death) **Physician** Due to (or as a consequence of) Arteriosclerotic Cardiovascular Disease /Medical 20 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine THE TIFICATION APPROVED BY MEDICAL EXAMINER Myocardial Infarction 72 hours Due to (or as a consequence of): iclan/Medica **IF FEMALE:** 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 2 ☐ Fetal death 3 Ectopic pregnancy Day Year 4☐ Pregnant at time of death 5 Other (specify) Physi 9 Unknown 9 Unknown Part fl. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š RETROPERITONEAL BLEED Pneumothorax with Central Line 1 X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Placement 4 1 2 2 perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 Yes 20 No ٩ 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: 5 Pending 2 Accident investigation 07/01/2006 1500 p^{M} 1 ☐ Yes 2 ☐ No Central Line Placement 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) St Joseph's 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hosital, Towson, MD Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier

physicien and s the burial-transit Box 68760. 8 the as attending nse ō ed by the a detached for Ö ۵. signed I Records, hes certificete Division of Vital : After this certifical funeral director, Attending death. Director: d in by the in by hours after Hospital or filled within 24 hours a

ir than "naturel", or iteme 23a or 28e-f ehow the Medical Examiner must be notified at

is marked other than

Examiner

should be in

hours after

Maryland 21215-0036

Baltimore.

State Registrar

31. Date filed (Month, Day, Year) JUL 0 6 2006

29b. Signature and Alie of certifier

(Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D24034

29d. Date signed (Month, Day, Year)

/Medical Examiner Physicien: The law requires that the death certificate be executed physicien and the burial-transit Box 68760, esn ţ ed by the a detached f Division of Vital Records, P.O. been signed be should be deta certificate has : After this certification : After this certification. or Attending death. within 24 hours after death To the Funeral Director: completely filled in by the

2 Certification:

Funeral

Director

r then "natural", or Items 23s or 28s-f show the Medical Exactly of invalide political at

within 72 hours after

d 2 should be filed within 7 th and Mental Hygiene.

Pages 1 and 2 nent of Health a ent: If item 27 is

permit. Page Depertment of Importent: If any injury or once

Physician

Baltimore, Maryland 21215-0036

Medical

0,

▶ NOOMVSQ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a Cortifier

4 Homicide

(Check only one)

5 Pending

investigation

6 Could not be determined

- RESIDENT

28a. Date of Injury (Month, Day Year)

29c. License number RES 060

28c. Injury at Work?

1 TYes 2 TNo

м

1 Certifying Physician: To the least of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

JUNE, 30, 2006

28d. Describe how injury occurred

3001 S. HANDUER STREET BALTIMORE, MD 21225

State Registrar

AMUSA NOZENYUY NTATIN, 31. Date filed (Month, Day, Year) JUL 0 6 2006



28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HARBOR

		1 - For State Registrar		of Marylar		artment of rtificate of			Reg. No.	2006	209	82
Phys /Me	ician dical	1. Decedent's Name (First, M Emil Eichh						2. Date of D Month July	Death 1 Day	2006	3. Time of 9:30	P M
Exar	niner	4a. Facility Name (If not instit	Court	number)		4b. City, Town, Lutherv	ille		Ba	County of Death 1timore		
Funer Direct		5. Social Security Number 219-30-8548 Usual Residence of Deceden	6. Sex 1 M 2 □ F	7. Age (In yrs. 74	last birthday) Yrs.	If Under 1 Year Months Day		Min. 8. Date of B (Month, L Aug. 5	Birth (Pear) 193	9. Birthp Coul	elace (State or htry) Esto	
Maryland	tor	10a. State 10b. Cou			ty, Town or Lo					1	0d. Inside Cit	
and 21215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. od other than "natural", or Items 23s or 28s-f show event, the Medical Examinar must be notified at	rai Director	10e. Street and Number 206 Lynncrest	Court			10f. Zip Code 21093			10g. Citiz	zen of What Cour	ntry?	
)36 irs after dea tr, or Items	by Funerai	11. Marital Status 1 Never Married 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Armed I ☐ Yes	2 🔼 No Sive		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 🕅 N		igin? (Specify Yes or N n, Puerto Rican, etc.)		4. Race - Americ Black, White, Specify: White	etc.	
Maryland 21215-0036 to 2 should be filed within 72 hours aff its and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exemi	Completed	15. Dece (Specify only hi Elementary/Secondary (0-1	dent's Education ghest grade completed		(Give	dent's Usual Occ kind of work don OO NOT use retii	e during mos red)	et of working	16b. Kin	nd of Business/In		
land 21 Id be filed will ental Hygien ked other th	Be	17. Father's Name (First, Mid	die, Last)		Chemic	al Engi	18. Mothe	er's Name (First, Middl		Mical Sumame)		
Taryig	J.	19a. Informant's Name/Relat	onship (Type, Print)				et and Numbe	a Madisson or Or Rural Route Num				
of Head		Helen K. Eich 20a. Method of Disposition 1 Burial 2 Cremati	on 3 Removal from	n State	Place of Dispo cemetery, crer	ynncres sition (Name of natory or other pi ervice (lace)	t; Luthery Date 7/7/06	20c. Loc	cation - City or To		
Baltimore, permit. Pages 1 ar Department of Hez Important: If Item sny injury or othe	SUCE.	4 Donation 5 Othe 21. Signature of Fin (a) Se	4	110	22	. Name and Add	ress of Facilit		105	on, MD 50 York wson, MD		
8760, A sate be executed xate be executed xate business and the burial-transit the burial-transit	icai Examiner	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	O (or as a consector of cor as a cor as a consector of cor as a cor as a consector of cor as a consector of co	quence of):	can	nei				Interval Betw Onset and D	eath
cords, P.O. Box 66 wequires that the death certifica been signed by the attending ph should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	utcome of pregna birth 2 Feta gnant at time of conown	al death 3	Ectopic pregnan Other (specify)	су		2:	3d. Date of delive Month	*	ear
ecords, P.O law requires that the as been signed by th 2 should be detache	þ	Partii. Other significant con		death but not res		nderlying cause g	iven in Part I.			se contribute to the		
Re la The la ate has page 2	Completed							per	opsy formed?	death?	psy findings ampletion of cal	vallable use of
- × v 0	To Be	25. Was case referred to med examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA O	thor	of Death Check only		□Other (Specifi	<u></u>	
Division of vithe Hospitel or Attending Phywithin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Certification: 1	2	28a. Date (Mosstigation and Indian (Mossing and Indian Ind	e of Injury nth, Day Year)	28b. Time of Injury	28c. Inj		28d. Describe			,	
DIVI Hospitet or At thours after d Funerel Direct tely filled in by		4 Homicide det	ermined 286. Place	ce of Injury · At h ding, etc. (Specia	fy)			City or To	own, State)	Number or Rura		ar,
To the Hos within 24 ho	Medical	29a. Certifier 1 Certi (Check only 2 Medi one) 29b. Signatus and the offer	cal Examiner; On the and ma	basis of examina	ation and/or inv	estigation, in my	time, date an opinion, deal	d place, and due to the th occurred at the time	, date and p	and manner as st place, and due to signed (Month, i	the cause(s)	
500		30. Name and address of pers	con who completed car		n 23a) (Type	Print)	24/2	2/	7/	2/06		
Regi	State strar	BRUCE 31. Date filed (Month, Day, Yo		JBERG Registrar's Signa	ature	21 WE	57	RD 7	OWS	en M	D 212	104
DHMH 17 Rev	-131 6	JUL	6 2006	ROS .	ORIGIN	VAL.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] § Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death June **Physician** 26 2006 Рм 6:58 Robert Ε. Engle /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Pasadena 414 Edgewater Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 932 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 73 NY Yrs. 094-26-9532 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Pasadena Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21122 USA 414 Edgewater Road items 23a death v Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status tiled within 72 hours atter 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: o. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 2 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation during most of working (Give kind of work done du life. DO NOT use retired) permit. Pages 1 end 2 should be tiled within Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "r. sny injury or other treumatic event, the Med once. Elementary/Secondary (0-12) College (1-4or 5+) Solid State Technician Westinghouse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sollitto Charles Engle Maria 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (spouse) Barbara J. Engle 414 Edgewater Road. Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 03 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 2006 21. Signature of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasădena, MD 21122 aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, jach line. 23a. Part I. Enter the disease, or complications that shock, or heart failure. List only one can see of Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ancrentic Physician hree /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certiticate hes been signed by the attending physicien end Kirector, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed the attending physicien end Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 ☐ Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by (Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ nia 2 /2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Atter this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospitel or Auterways within 24 hours after death.

To the Funerel Director: All 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day

32. Registrar's Signature

KALEEN FOSTER 06-04629 UNK UNK

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 30081 1- For State Certificate of Death Reg No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month D. D. July 2, 2006 Day 0347 hrs Medical Examiner Foster Kareem Lewis 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Shock Trauma Baltimore If Under 1 Year If Under 24Hrs. 8 Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Director 10-10-1984 219-06-8201 \mathbf{X}_{M} 21 Country Md 2 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location any 1 X Yes 2 No Baltimore or 28a-f show Md items 23a or 28a-f shoust be notified at once. N/A hours after death with the Maryland Director 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 21212 5519 Lothian Road Apt 1 S A 14. Race - American Indian, Black Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11 Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 X No Yes Specify Black 4 Divorced If Yes, Give Year Yes 2X No specify: Widowed Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygene
Important: I filem 27 is marked other than "natural",
injury or other tranmatic event, the Medical Examiner. þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry N/A leted during most of working life DO NOT use retired) Elementary/Secondary (0-12) N/A Compl 11th grade 18 Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Nadine Oliver Collie Lewis Foster 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nadine Oliver 5519 Lothian Road Apt 1 Balto, Md 21212 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a, Method of Disposition crematory or other place) X Burial 2 Cremation 3 Removal from State 7-7-2006 King Memorial Park Donation 5 Other Specify Randallstown, Md 22. Name and Address of Facility March F/H Sinnato e of Funeral Service Lice West 4300 Wabash Avenue Balto, Md 21215 Approximate Interval Between Onset and art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** ailure. List only one cause on each line /Medical Death a Multiple Gunshot Wounds nediate Cause (Final disease Examiner condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certificate be executed and /sician/Medical UNPENDED AMENDED Box 68760, ng phys as the bu IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Live birth Fetal death 3 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? No ✓ Yes 2 1 🗸 Yes 2 No certificate 26. Place of Death (Check only one 25. Was case referred to medical Fo the Hospital or Attending Physician: Be Other₄ Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 After this 1 🗸 Yes 28a. Date of Injury Jul 2, 2006 27 Manner of Death 28b. Time of Injury 8c. Injury at Work' 28d Describe how injury occurred Certification: Subject shot 0251 hrs Natural 1 Yes 2 V No 5 Pending 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State determined (Specify) Local Street 600 Cherrycrest Road, Baltimore, Md. within 24 hours a 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Wedical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d Date signed (Month, Day, Year) 29b Signature and title of certifie 9 O.C.M.E. July 2, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner Jack Titus MD. 32 Registrar's Signature 31 Date filed (Month, Day, Year) State 0 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 🕦 🗎 🖯 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** July 1, 2006 MARY BERNADETTE FIELDS 8:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maria Health Care Center Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1940 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2/X Mary Land 218-38-0753 Yrs. 65 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-fahow other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes XX No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? -0 6401 North Charles Street 21212 USA 238 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Examinations. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Parochial School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Louis Fields Bernadette Wolford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Feilinger SSND 6401 North Charles Street Baltimore Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Villa Maria Cemetery | 7/6/06 Glen Arm, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Neuroblastoma Multiforme disease or condition resulting in death) 12 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) ed by the attending physicien and detached for use es the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Seizure Disorder 2 No 1 Tes Division of Vital To the Hospital or Attending Physician: : After this certification funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Tes 2 No ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying hysisian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56623 July 5, 2006 who complete cause of death (Item 23a) (Type, Print) 30. Name and address of Dr. Jin Gu, 7505 Osler Drive Towson, Maryland 21204 Bay, Year) 31. Date filed (Month 32. Registrar's Signature State Registrar

			1 - For Stete Registrer	State of Ma	arylan		tment of H			giene Reg. No.	2006	20986
	DI		1. Decedent's Name (First, Middle, La	st)					2. Date of Dea	ath Day	Year	3. Time of Death
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	Examir		4a. Facility Name (If not institution, give				4b. City, Town, or		_	4c.	County of Deatt	n
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	Funeral Director		214-58-6795	Sex 7. Age	6 (In yrs. _54		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		y, Year)	Col	nplace (State or Foreign untry) MD
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loca	ition					10d. Inside City Limits
	Aaryl Peho	ō	MD		DAT	TIMORE						1 XYes 2 No
	288-	rect	MD 10e, Street and Number		DAT	11 THOKE	10f. Zip Code			10g. Citiz	en of What Co	untry?
	Sa or	ā	730 W. FAYETTE S	ו יווערוג יוד	5		21201			USA		
	death	era	11. Marital Status	12. Was Decedent B		.S. 13. Wa	as Decedent of H	ispanic Origin? (Specify Yes or No-		4. Race - Amer	
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ဇ္ထ	raif, o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		11]Yes 2⊠No	Specify:			Specify: BL	ACK
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	e filed within al Hygiene. i other then ' vent, Ine Ma		10TH 17. Father's Name (First, Middle, Last	<u> </u>		HOUSE	(EEPER	10 Mothada N	ama (Cirat Middle		ERNMENT	
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2	should and Men a marke umatic	2	JAMES WALKER	Time Drine)		10h Mailine	Address (Street		IN FALCON	r City or	Tourn State 7	in Codel
Maryland	od 2 st Ith and 27 ts r traur		19a. Informant's Name/Relationship (1			Rural Route Numbe			ip Code)
as .	8 E E		MARTY CARTER/NIE 20a. Method of Disposition	<u> </u>	20b. F	lace of Disposit	IRONCLIF.		ESSEX, M		1221 ation - City or 1	Town, State
Baltimore,	permit. Pages 1 Department of H Important: If ite eny injury or ot once.		1 Burial 2 Cremation 3			-	tory or other plac		7/2006			Fown, State NELL ST.
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⋚	Physician: this certific ral director,	00	examiner?	Hospital:	nt 2	ER/Outpatient	3 DOA Oth	00	eath (Check only o		□Other (See	6.1
o		. To	27. Manner of Death	28a. Date of Inju		28b. Time of	28c. Injun		28d. Describe t			ny)
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai (29a. Certifier 1 Certifying P	hysicien: To the best of miner: On the basis of	examina	wledge, death outline	occurred at the tin stigation, in my o	ne, date and pla- pinion, death oc	ce, and due to the coursed at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s)
	ithin 2 or the	Med	29b. Signature and title of certifier	and manner sta	neu.		29c. Licens	e number		29d. Date	signed (Month	, Day, Year)
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•	3		30. Name and address of person who			n 23a) (Tvoa De	rint)					
	2	1	22 S. Greene St.				201 ,	Carol	Ma, M	D		
	Sta	ate	31. Date liled (Month, Day, Year)	32 Registra			ali)					

			for State Registrar	State	of Marylai	nd / Dep <i>Ce</i>	artment c	of Health of Death	and M		giene 2 Reg. No.	006	20987
9	A. Francisco		Decedent's Name (First, Middle	Last)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	J D O G ()		2. Date of De			3. Time of Death
40.	Physici		ISABELLE A.	FLEAGLE						Month	Day	Year	3:44 Am
	/Medic Examir		4a. Facility Name (If not institution,		ımber)		4h City Toy	vn, or Location	of Death	July		2006 ounty of Death	3,110
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	Euparal	100		6. Sex		. last birthday)	If Under 1 Y	ear If Under		8. Date of Birl	th	9 Birthol	lace (State or Foreign
	Funeral Director		212-10-9422	1□M 2🖫 F	89		Months Da	ays Hours	Min.	3/8/19	y, Year)	Coun	try)
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	ylang		10a. State 10b. County		10c. C	ity, Town or Lo	ocation		_			10	0d. Inside City Limits
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	h the	Director	10e. Street and Number		· ·		10f. Zip Co	de			10g. Citizer	of What Coun	try?
	th will		8333 HILLENDALE	ROAD			2	1234			US	SA	
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examiner must be positived as	Funerai	11. Marital Status		edent Ever in U	J.S. 13.	Was Decedent	of Hispanic Or Cuban, Mexica	igin? (Spe	cify Yes or No	- 14.	Race - America	
9	or Ite		1 ☐ Never Married 2 ☐ Marrie		2X No		1 ☐ Yes 2 X ☐			ncan, etc.)		Black, White,	etc.
8	ral',	d by	3X Widowed 4 ☐ Divorced	Year or D	ates:		10 105 200	No Specify:	•		Sp	pecify: M	/HITE
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Maryland	2 sh land larr		19a. Informant's Name/Relationsh							Route Numbe	er, City or To	own, State, Zip	Code)
	and lealth m 27 her t		JEAN F. REINHOL	D/DAUGHT			+	AY ROAL	-	LTIMORE		21286	
0	ges 1		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from	01-11	cemetery, crei	sition (Name o	place)		ate		ion - City or To	
Ē	Pag men mant: lury		4 □ Donation 5 □ Other (Sp		UES		TH. CH.		7/6/			YSVILLE	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It a Madical Extending round by notified at page.		21. Signature of Funeral Service L	N. X. Kee	Y	8.	2. Name and Ad 521 LOC	ddress of Facili H RAVEN	THE BLV	JOHNSO	ON FUN	ERAL HO D 2128	ME, P.A.
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that	aused the dea								Approximate
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in the second	/Medical		resulting in death)	a. VIO2	(or as a consec	h yoca	Mai	Inta	16 17 6	0/1			
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Вох	death certifi e attending id for use as	an/h	23b. Was decedent pregnant		tcome of pregnation		Ectopic pregna	ancv			23d.	. Date of deliver	у
	a dea	sici	in the past 12 months? 1 ☐ Yes 2 🗷 No		nant at time of c		Other (specify					Month (Day Year
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	The law requires that the death certif te has been signed by the attending bage 2 should be detached for use a	by Physician/Me	Part II. Other significant condition	s contributing to d	eath but not res	sulting in the u	nderlying cause	given in Part I.		23e. Did to	bacco use	contribute to the	cause of death?
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<u>ita</u>	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?					26. Place	of Death	(Check only or			<u> </u>
>	nysic als ce dire	P	1 Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatien	t 3 DOA	Other				Other (Specify)	1
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<u>Ö</u>	endin sath. or: A	atic	2 ☐ Accident investiga	ition		,,,,,		1 Yes 2 🗆	No				
Division	after death after death Director: I in by the	Certification;	3 Suicide 6 Could no 4 Homicide determin	ed 289. Place	of Injury - At hing, etc. (Specia	ome, farm, str	eet, factory, offi	ice	2	8f. Location (S City or Tow	treet and Ni	umber or Rural	Route Number.
	ital c irs af ral Di led ir												
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edicai	29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the xaminer: On the b and man	best of my kno asis of examina ner stated.	owledge, death ation and/or inv	occurred at the restigation, in m	e time, date an ny opinion, dea	id place, ar th occurre	nd due to the c d at the time, d	ause(s) and late and pla	manner as sta ce, and due to t	ted. the cause(s)
	To th Mithir Comp	Me	29b. Signature and title of certifier	7/ 1/			29c. Lic	ense number		2	29d. Date si	gned (Month, D	lay, Year)
	,		Vathoro.	Veello.	MD		701	0008	5 (07/1	25/20	66
	/		30. Name and address of person w	ho completed caus	se of death (Iter	n 23a) (Type.		- 000			1/6	2/20	UK
	5		V	efe Do	_			ven BI	WD -	BAITIN	nove L	10 212	39
*) }	Sta	te	31. Date filed (Month, Day, Year)	-	egistrar's Signa		-,		4101	3		., -10	
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			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of F rtificate of i			ene2006 g. No.	20988
	Physici	an	Decedent's Name (First, Middle, in the control of the control	,				2. Date of Death Month	Day Year	3. Time of Death
	/Media			M. Federic	:0			JUL	Y 2, 200	
7	Examir	ier	4a. Facility Name (If not institution, g Saint Joseph		Center	4b. City, Town, o	r Location of Deat Tows		4c. County of Deal	n timore
	Funeral Director		5. Social Security Number 6 212-09-6959		e (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			hplace (State or Foreign puntry) aryland
	land w		Usual Residence of Decedent 10a. State 10b. County	-	10c. City, Town or Lo	cation				10d. Inside City Limits
	Many i-f ehr	ţ	Md. Ba	ltimore		Timor	nium			1 ☐ Yes 2 🖔 No
	or 28s	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	ath wi	rai	12261 Roundwoo				21093		USA	
39	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. ie marked other then "naturei", or items 23a or 28a-f ehow aumatic event, the Madical Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 Yes, Give Year or Dates:	10	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
Š S	72 hor	Completed	15. Decedent's (Specify only highest of	Education	16a. Deced	dent's Usual Occup	ation	rting 1	6b. Kind of Business/	
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Maryland 21215-0036	Mental I	To Be	Filmo				TO. WOULD STAN		rist	
ary	s 1 and 2 should f Heelth and Men Item 27 ie marke other traumatic	-	19a. Informant's Name/Relationship		19b. Mailin	g Address (Street	and Number or Ru		City or Town, State, 2	Zip Code)
	9 £ N 5		Mrs. Mary Heffern	an/Daughter		Trickling	Brook F	The state of the s	eysville,	Md. 21030
Baltimore,	ges 1 t of H if iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	:e)	Date 2	Oc. Location - City or	Town, State
	it. Pertiment:	, y	4 □Donation 5 □ Other (Spec	cify)	Dulaney Va				imonium, M	
Ba	permit. Peges 1 and Department of Heeli importent: if item 2 any injury or other 2000s.		21. Signature of Funeral Service Lic	of Rushy	1	. Name and Addres	Road To	owson, Mar	ryland 212	Home, Inc. 04
п			23a. Part1. Enter the disease, or shock, or heart failure. List on	mplications that caused ly one cause on each lin	the death. Do not entered	ar the mode of dyin	g, such as cardiad	or respiratory arres	st,	Approximate Interval Between
j	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. HYPERC						Onset and Death
	Examiner		1	Due to (or as a	a consequence of):					
		ě	Sequentially list conditions,	D	à consequence of).					
	cuted nd ransit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. HYPERT	ENSION					
Ď	oe exe cien a vuriat-l		resulting in death) Last	· ·	a consequence of):					
68/60,	ifficate be executed g physicien and as the burial-transit	edicai		d BRAIN	TOMOR					
O. Box	the death cert y the attendin iched for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 UNo 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at 19 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
ري ح	w requires that been signed b should be deta	by Pi	Part II. Other significant conditions	contributing to death bu	it not resulting in the un	iderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ecords,	equire	ted						1 🗆 Yes	2 □ No 3 □ Pro	obably 4 Nnknown
r	The law ete has b page 2 st	Completed						24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
Vitai	sician: certifice rector, p	Be	25. Was case referred to medical examiner?	Hospital:		3 DOA Othe	_	th Check only one		-
Ö	this aid	2	1 ☐ Yes 2 No 27. Manner of Death	28a. D te of Injun	v 28b. Time of	JU DON	+ □ INDISHING IT	ome 5 Residen	ce 6 Other (Spec	arfy)
0	nding F ath. r: After e funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident Investigate	(Month, Day ion	Year) Injury	28c. Injury Work	r? Yes 2 □ No		,,	
DIVISION	7 5 F C	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		iry - At home, farm, stre . (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital of within 24 hours at To the Funerel D completely filled in	Medical (29a. Certifying F (Check only one) 2 Medical Ext	Physician: To the best of aminer: On the basis of and manner stat	examination and/or inv	occurred at the tim estigation, in my op	e, date and place pinion, death occur	, and due to the cau rred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	1		29c. License	number	290	d. Date signed (Month	/
)		4	•		_	D 52	749		07/03/	1200 6
	1		30. Name and address of person wh						7	
	Sta	te	JAYANT F. HIR 31. Date filed (Month, Day, Year)	PARA M. D. 32. Registra	7601 C	SLER DR	IVE, TO	WSON, M	ARYLAND	21204
	Registr			2006		nach)				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Carol Ann Follin June 30 2006 11:56 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. Director 219-40-6741 64 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show or iteme 23a or 28e-f show obsermost by notified at 1 Tes 2 No Director MD **Baltimore** Cockeysville 10e. Street and Number 10g. Citizen of What Country? 17 Warren Lodge Ct. Apt. A 21030 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White ģ Specify 3 ☐ Widowed 4 ☐ Divorced "natural" I'm Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 11 Receptionist n/a Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ls markad Richard Rosenberger Ida Dignan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 19a. Informant's Name/Relationship (Type, Print) f Health item 27 I Bryant Clifford Follin/husband 17 Warren Lodge Ct. Apt. A, Cockeysville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H importent: If ite any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) 7/3/06 Baltimore, MD Gardens of Faith Cemetery Tomate on Ful of the Licente 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Bryan W. 23a. Part1. Inter the disease, or complications that cau shock or heart ailure. List only one cause on ea the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (mal disease or condition resulting in death Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sicion and burial-transit The law requires that the death certificate be executed Box 68760, Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Year 4 Pregnant at time of death signed by the a 5 Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has the 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No of Vital or Attending Physicien: 25. Was case referred to medical examiner? To Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funerel Director: After thi completely filled in by the funeral 27. Manner eath 28c. Injury at Work? Medical Certification: 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Division Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 T Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29b. Signature and title of cert 29d. Date signed (Morith, Day, Year) Robert Gattuso, M.D. 16940 York Rd., Monkton, MD 21111 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 6 2006 Registrar

			State of Maryland / Department of Health and M 1- State of Maryland / Department of Health and M Certificate of Death		iene 2006	20990		
	0		1. Decedent's Name (First, Middle, Last)	2. Date of Deati		3. Time of Death		
	Physici		PETER MIMZEY FEDAS	Month 7	Day Year	735 AM		
1	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	10-		
	L X da i jiii	Ci	CITIZENIS NURSING HOME HAVEE DE GI	RALES	HAREN	, 1		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign		
	Director		164-22-1280 10XM 2□ F 78 Yrs. Months Days Hours Min.	May 31,	Year) Cou	sylvania		
	Ţ		Usual Residence of Decedent	, <u>, , , , , , , , , , , , , , , , , , </u>				
	rylan how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
	e Ma	cto	Maryland Harford Forest Hill			1 ☐ Yes 2 ☐ No		
	ith th	Sire	10e. Street and Number 10f. Zip Code	10	0g. Citizen of What Cou	ntry?		
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show re Modical Examinar must be notitied at	Funeral Director	109 Calder Court 21050		USA			
	r dez	Ine	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,			
36	or it		1 Never Married 2 Married 1 Na Yes 2 No 1 Yes 2 No Specify:		Specify:			
21215-0036	hour:	d by	3 XWIdowed 4 Divorced Year or Dates:		Wh	ite		
5	"nat	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of workir life. DO NOT use retired)	n <i>g</i> 1	16b. Kind of Business/Ir	dustry		
12	withir	E E	Elementary/Secondary (0-12) College (1-4or 5+)					
d 2	filed Hygie other		17. Father's Name (First, Middle, Last) 4 Accountant 18. Mother's Name		J.S. Governi	ment		
Maryland	d be intal	Be c	John (nmn) Fedas Elissa (1		,			
\geq	should be and Mental is marked c	2	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street</i> and <i>Number or Rura</i> .	<u>`</u>		Code		
E	d2s thar thar trau		Cara-Marie Meckley/ Daughter 109 Calder Court, Fores			, , , , , , , , , , , , , , , , , , , ,		
á	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Heatth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, It a Madical Examinar must be notified at	1 3	20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or To	own, State		
Baltimore,	Pages nent of I int: If its		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Lill+on Commission Commission 7—5—6		200			
⋣		ŀ	21. Signature of Funeral Service Licensee		lowson, Mary	yland		
Ba	permit. Departn Imports any inju		McComas Funeral Home	e, P.A.				
			23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	, Abingo	ion, MD 2100	Approximate		
	227.00		The state of the s	, respiratory unit		Interval Between Onset and Death		
	Pnysician /Medical		disease or condition resulting in death)					
	Examiner		Dive to (or as a consequence of):					
		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
	ficate be executed physician and sthe burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury					
	al-tra	Exal	that initiated events c. resulting in death) Last Due to (or as a consequence of):		-			
8760,	cate be executed physician and the burial-transit	dical	7/ Werfir WANITUS	•				
89	ificate p phy as the	edic	0. 20(1.5.) 1.0.					
Box	death certifi e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delive	erv		
ñ	death e atte d for	cla	in the past 12 months? 1 Vos 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year		
0	at the de by the a	hys	9 ☐ Unknown 9☐ Unknown					
Д,	s thai	by P	Panal. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?		
ğ	equires sen sign tould be		Prempiler	1 ☐ Yes	s 2□No 3□Prob	ably 4 Unknown		
Vital Records,	2 0 5	Completed	History of Hemomenan Stant	24a. Was an	24b. Were auto	psy findings available		
Re	The lav	шс		autopsy perform	prior to co- death?	mpletion of cause of		
tal		a	25. Was case referred to medical 26. Place of Death		☑No 1 ☐ Yes	2 No		
	Physician: this certific ral director,	0 0	examiner?		nce 6 Other (Specif	4)		
o	g Phy er thi	E i	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	8d. Describe hov		//		
_ <u>_</u>	nding F th. :: After e funer	atlo	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No					
Division	al or Attendi after death. I Director: A d in by the fu	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 2:		eet and Number or Rura	l Route Number,		
Ö	al or s afte	Cert	4 ☐ Homicide building, etc. (Specify)	City or Town,	State)			
	e Hospital 24 hours a e Funeral letely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	nd due to the cau	use(s) and manner as si	ated.		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, dat	te and place, and due to	the cause(s)		
	To the within 2 To the complet	Ž	29b. Signature and title of ceptifier 29c. License number	29	d. Date signed (Month,	Day, Year)		
			V[1744 414 11464]		7/3/00			
	10+1		30. Mame and address of person who completed cause of death (Item 23a) (Type, Print)		1.30			
_	ſo,			hp 2	1018.			
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		1			
	Registr	ar	VOL V COUNTY AND AND AND AND AND AND AND AND AND AND					

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of F			giene 00	5 20991
	A. E. B.	7	Decedent's Name (First, Middle, La	ist)				2. Date of Dea	ith	3. Time of Death
-	Physic /Medi		Umberto (arlo G	iannori			Month	Day Ye 200	
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death	30,9	4c. County of [
			Joseph Richie	Hospice		Ba	1timore		N	A
40	Funeral	8	Social Security Number 6. 5	Sex 7. Ac	ge (In yrs. last birthday,	If Under 1 Year Months Days		8. Date of Birth (Month, Day	y Year) 9.	Birthplace (State or Foreign Country)
	Director	fi.	223-25-0706	1 M 2 F	65 Yrs.	Wionais Bays	Tiours Willing	December 1		Italy
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation			-	10d. Inside City Limits
2	Aaryli Fsho	ō	Virginia Fairf	- >/		xandria				Yes 2 □ No
2	the f	ect	10e. Street and Number	ax	Alex	10f. Zip Code			10g. Citizen of Wha	
+	With Ba or	٥	5904 Mount Ed	acle Day	10	· ·	303		US	
7	ours after death with the Maryland rat', or feme 23a or 28a-f show Exercited must be notified at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13.		Hispanic Origin? (Sp	ecify Yes or No-		American Indian,
11	or free	Fur	1 Never Married 2 Married	Armed Forces	?	If Yes, specify Cub	oan, Mexican, Puerto	Rican, etc.)	Black, V	Vhite, etc.
/A 5-0036	hours after tural', or Ite	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: V	white
5-0	72 hours "natural"	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	edent's Usual Occup	pation during most of work	ing	16b. Kind of Busine	ess/industry
2	within ene.	npje	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retire	ed)		110001	J. 1917
202	e filed w Il Hygier other tl	S	47.5 (1.1)			lestaur.	anteer		<u> </u>	tality
one one	be fi	Be	17. Father's Name (First, Middle, Last	f			18. Mother's Name			1163
~ \frac{1}{2}	2 should be and Mental is marked o	T _o	19a. Informant's Name/Relationship (405 11-11	(7)	Luiq		Trade	
$/\psi/o$ (Maryland	C1 (0 = @		۸ ،	/ Wife			and Number or Run		•	
is 1	1 and Health em 27		Anna Gianner	7 00176	20b. Place of Disp	osition (Name of	Eagle Dr		20c. Location - City	
ě	Pages nent of I nt: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐		cemetery, cre	matory or other pla	109)			
4 altimore,	그는민군		4 Donation 5 ☐ Other (Specifical Signature) of Funeral Service Lices		MectonyGi	stinzenist	ess of Facility And	2006	Hanover	MID
Ba	permi Depa Impo any is		1			22 Cone			the regarding	MA 2:
			23a. Part1. Enter the disease, or com	plications that cause	d the death. Do not en			Suite (est.	Approximate
	Dhysisian		Immediate Cause (Final	one cause on each li	ine.			,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	s a consequence of);	. Carcine	me			2 months
2	Examiner		1	Due 10 (01 as	a consequence on.					
9		Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):		-			
3	ansigned of	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6						
60	execut		resulting in death) Last	Due to (or as	a consequence of):					
/A, 8760	cate be executed by sicien and the burial-transi	dicai	(d						
0 0	ntifica ng ph as th	Med	IF FEMALE:							
S C	ith ce tendi	an/I	23b. Was decedent pregnant	23c. If yes, outcome 1☐Live birth		☐Ectopic pregnancy	v		23d. Date of	*
- O	ne death certifi the attending I hed for use as	Sici	in the past 12 months? 1 Yes 2 No	4☐ Pregnant a 9☐ Unknown		Other (specify)			Month	Day Year
10 9	ac of	by Physician/Me	9 Unknown			- 1 1 1		00 - Did		
i,	signed det	þ	Part II. Other significant conditions of	contributing to death b	out not resulting in the u	indenying cause giv	ven in Part I.			e to the cause of death? Probably 4 Unknown
of g	v requ been should	etec							es 2 140 3	Probably 4 Unknown
ER Records	e law has b	Completed						24a. Was a autops	sv prior	autopsy findings available to completion of cause of
€ E	cate							perform 1 ☐ Yes	med? deatl	1? (es 250 No
2 =	Physician: The lavible serificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		0#	26. Place of Death	(Check only on	16)	
7 5	Phys this al di	- To	1 Yes 2 No 27. Manner of Death	1 🗆 Inpatie			4 🗆 INUISING HO	me 5 Reside		ipecity) Hospice
	Attending r death. sctor: After by the funer	tion	1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) Injury	Wor	rk? Yes 2 □No	280. Describe no	ow injury occurred	
) Division	deat deat ctor: y the	fica	3 Suicide 6 ☐ Could not b	e Diago of lai	jury - At home, farm, st			28f Location (St	treet and Number of	Rural Route Number,
D.	after Dire	Certification:	4 Homicide determined	building, et	tc. (Specify)	oot, radiory, omoo		City or Town		Floral Flogio Hamber,
	Hospital 4 hours a Funeral I tely filled		29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowledge, deat	h occurred at the tir	me, date and place,	and due to the ca	ause(s) and manne	as stated.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Exar	niner: On the basis o and manner st	of examination and/or in	vestigation, in my o	opinion, death occurr	ed at the time, da	ate and place, and	due to the cause(s)
_	To the within 2 To the complet	M	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (M	onth, Day, Year)
			Dwilliam (enedict.	ms	700	8583		07/06/0	6
	20		30. Name and address of person who	completed cause of o					- 10670	
	0,		6. WILLIAM BENE	DICT 15	death (Item 23a) (Type,	ALE ST.,	Bactinovz	, MD. 2	1217-41	20
	Sta		31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	Se)				
	Registr	ar	JUL 0 6 2008	3 11/10/19/19/19	No. Jahren	1945				

			State of Maryland / Departme		ental Hygien	enns 2ngg2
				ate of Death	Reg. N	L 000 2.0772
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month, D	3. Time of Death
	/Medic	al	Oliver Green		July 3	3 2006 5 P'M
	Examin	er	D1 D1 L1	ity, Town, or Location of Death		c. County of Death
	Funeral				8. Date of Birth	9. Birthplace (State or Foreign
	Director		226-20-1894 174 20F 80 Yrs. Month	ns Days Hours Min.	8. Date of Birth (Month, Day, Yea	925 Your Civia
ī	D D		Usual Residence of Decedent		00,1	ro viginioc
	show	_	10a. State 10b. County 10c. City, Town or Location	++"	•	10d. Inside City Limits
	88a-1	ecto	1110 10 10 Da	Mimor		12 Yes 2 No
	with ti	直	10e. Street and Number	Zip Code	10g. C	Citizen of What Country?
	after death with the Maryland or Items 23a or 28a-1 show	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De	cedent of Hispanic Origin? (Spec	ify Yes or No-	14. Race - American Indian,
0	r Iten	Fun	Armed Forces? If Yes, s	pecify Cuban, Mexican, Puerto R	ican, etc.)	Black, White, etc.
200	72 hours after natural', or Ite lical Examina	by		200 No Specify:		Specify: Black
ם ה	72 ho	Completed	15. Decedent's Education 16a. Decedent's U (Specify only highest grade completed) (Give kind of	sual Occupation work done during most of working	16b.	Kind of Business/Industry
V	nthin ne. han "	mpļ	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT	Tuse retired)		niversity,
V	filed within Hygiene. other than "	ပိ	17. Father's Name (First, Middle, Last)	Se feet 18. Mother's Name ((First Middle Maide	TOSPITAL
ā	d be f	Be	Oliser O Green	18. Mother's Name	First, Middle, Maide	T)
<u> </u>	should be nd Mental marked o	2	19a. Informant's Name/Relationship (<i>Type, Print</i>) , 19b. Mailing Addre	ess (Street and Number or Rural	Route Number City	or Town State 7in Code)
Z Z	and 2 : ealth ar n 27 Is		Joann Gilliard - niece 3/24	Cottage Ave	Balto	1
n,	item item othe	- 15	20a. Method of Disposition 1 Regural 2 Commation 3 Removal from State 20b. Place of Disposition (A cametery, crematory)	Name of Da		Location - City or Town, State
Ē	Pages nent of I int: If its iry or o		Tabanar 2 Graniation o Examovarion state	m. Park 7-8	-06 Ka	ndallstown, ma
Dallillio	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exartic at must be notified an once.		II. A	and Address of Facility 27	O Fred to	TILTON Pass
<u> </u>	82553		Say / War Gar		ineral Th	one talto, md, 2122
	17 25		23a. Part1. Ent of the disease, or o mplications that caused the death. Do not enter the m shock, or heart failure. List only one cause on each line.	of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ic Cardiova	scular	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	- 1		
		-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of);	Sordor		
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury			
Ś	exection and and rial-tra	Exa	that initiated events resulting in death) Last c. Due to (or as a consequence of):			
5	ficate be executed physician and the burial-transit	dlcal	d			
00	ng ph	6 0 1	IF FEMALE:			
200	ath ce ttendi	an/I	23b. Was decedent pregnant in the past 12 months?	pregnancy		23d. Date of delivery Month Day Year
	the a	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month Day Year
Ľ	w requires that the death certific been signed by the attending p should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I	23e. Did tobacco	use contribute to the cause of death?
S C C C	uires sign d be	d by	,	,		Probably 4 Unknown
2	w req	Completed			24a. Was an	24b. Were autopsy findings available
ב	he lar e has age 2	duc			autopsy performed?/	prior to completion of cause of death?
g	sician: The lav certificate has rector, page 2	0	25. Was case referred to medical	26. Place of Death (Check anly one)	o 1 ☐ Yes 2 ☑ No
>	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 ★ No	0.0		6 ☐Other (Specify)
5	Attending Physician: The lar death. rector: After this certificate he by the funeral director, page		27. Manner of _eath 28a. Date of Injury 28b. Time of		d. Describe how inju	
2	eath. or: A	catic	2 Accident investigation M	1 ☐ Yes 2 ☐ No		
10	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ory, office 28	 Location (Street a. City or Town, Stat 	nd Number or Rural Route Number, e)
7	pital ours a eral I		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurre	and as the time of the and place are	d d	N - 1
	24 hc 24 hc Fun etely	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurre (Check only one) Medical Exeminer: On the basis of examination and/or investigation and manner stated.	on, in my opinion, death occurred	d due to the cause(s at the time, date an	s) and manner as stated. d place, and due to the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a:	Me	29b. Signature and title of certifier 2	29c. License number		ate signed (Молth, Day, Year)
	, , , , ,		Amotion M Macen MP	D 15503	Ju	14 6 2006
	Á		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	D 15503 liphin st	D 11.	200 20.2
	*\		AMATUM M MACEM 501 DO	ipnin ST	, Baltir	nore IVII) ald +
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 6 2006 32. Segistrar's Signature	J		
	negisti	21	Manual Manual	R)		

State of Maryland / Department of Health and Mental Hygiene [] 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 5.00 Any M WILLIAM LLOYD GREENE JUNE 21, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 829 N. GILMOR ST. BALTIMORE It Under 1 Year It Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Days 1 XM 2 ☐ F Yrs. Director 219-38-9282 63 11/23/1942 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. tnside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 829 N. GILMOR ST Funeral 21217-2123 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: BLACK 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Complet Pages 1 and 2 should be filed within inent of Health and Mental Hygiene. Int: if item 27 is marked other then " Elementary/Secondary (0-12) Coltege (1-4or 5+) TRUCK DRIVER 12TH FRIEGHT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be VERNON GREENE LUCILLE GREENE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other trai once. SANDRA GREENE/DAUGHTER 21217-2123 829 N. GILMOR ST., BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 5600 O DONNELL ST. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CARMEL CEMETERY 07/03/2006 BALTIMORE, MD 21224 21. Signature of Furniral Se 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part1. Enter the disease shock, or heart tailurg.
Immediate Cause (Final disease or condition resulting in death) e or complications that caused it he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** INFARCTION MYOCARDIAL UNKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funcatel Director: After this certificate has been signed by the attending physician and completely filled in by the Innoration director, page 2 should be detached for use as the buriat-transit completely filled in by the Innorational complete. Records, P.O. Box 68760. Due to (or as a consequence ot): Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death Year 5 Other (specify) 9 Unknown 9 Unknown Part tl. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? CANCER 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1☐ Yes 2X No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, tarm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 816629 July 7th, 2006 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIROKO BECK South Greene St, Baltimore MD 21201 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State make) Registrar 6

C

5-04657 onstance Dean G		Si	Pleas ate of Maryla	e Type or and / Depa						giene					
	1- For State Registrar			Cei	rtificate o	f Death					Reg 1	No	20(16	2090
Physician/ ledical Examine	1. Decedent's Nan		le,Last) Lynn	Dean	Gio	ordano)		- 1	Date of Month	Death Da		ear	3. Time of 0600 h	
accorded.	4a. Facility Name 586 Waywa		on, give street and ni	umber)		4b. City, To Annap		ocation of	Death			4c. Count Anne A	y of Deatl Arundel		
Funeral Director	5. Social Security 219-78-4		6. Sex	7. Age (In yrs. la	ast birthday) 9 Yrs	If Under Months	_	If Under: Hours	24Hrs. Min.	8. Date o	,		Foreig		te or
nd Show any ICE.	Usual Residence of 10a. State	10b. County	Arundel	,	Town or Local										City Limits
th the Maryland 23a or 28a-f show notified at once. al Director			a Cirle T2	2		10f. Zip (S.A.	What Cou	ntry?	
or items must be	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced If Yes, Give Year			S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No specify				No-	14. Race - American Indian, Black, White, etc. Specify: White						
5-0036 led within 72 hours after Hygiene other than "natural", the Medical Examiner Completed by	Elementary/Sec		college (de completed) 1-4 or 5+)		ost of work						b. Kind of E		industry	
5-0036 ed within 7 tygiene other than the Medica	12				Waitı	ess						Vaitr			
21215-0036 uld be filed within 77 Mental Hygiene marked other than r event, the Medical o Be Comple		17. Father's Name (First, Middle, Last) Robert T. Dean				18.Mother's Name (First, Middle, Maid Jeanne Marie Dai				,					
D 21 hould hould hould is mar is mar		19b. Mailin	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
MD d 2 sh Ith and In 27 is		Mr & Mrs Robert & Jeanne Dean				7847 Ameriana Circle T2 Glen									
altimore, MD 2 mit Pages I and 2 shou partment of Health and N portant: If item 27 is n ury or other traumatic	Burial Z X Cremation 3 Removal from State				crematory or ot	lace of Disposition (Name of cemetery, ematory or other place) Sapeake Cremation Date July 5, 2006				20c. Location - City or Town, State Stevensville, MD					
Baltin permit P. Departme Importan injury or	21. Signature of Fu	Oyner Superal/Service	Licensee	7/1137/5	22.1		ddress o	f Facility	Sing	leto	n Fu	inera	1 Hor	ne, P.	

Second Avenue SW Glen Burnie, MD 21061

24a. Was an autopsy performed?

Yes 2

Nursing Home 5 Residence 6 ✔ Other Scene

28d Describe how injury occurred

Subject fell down stairs

Approximate Interval

Between Onset and

Death

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 V No 3 Probably 4 Unknown

death?

28f Location (Street and Number or Rural Route Number, City or Town, State)
 586 Wayward Court, Annapolis, MD

July 3, 2006

29d. Date signed (Month, Day, Year)

✓ Yes

24b. Were autopsy findings available prior to completion of cause of

Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

3 Ectopic pregnancy

26 Place of Death (Check only one

Other₄

1 Yes 2 ✔ No

28c Injury at Work?

29c License number

O.C.M.E.

DOA

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Physician /Medical ⊊xaminer

Immediate Cause (Final disease

or condition resulting in death)

events resulting in death) Last

IF FEMALE⁻ 23b. Was decedent pregnant in the past 12 months?

25 Was case referred to medical

5 Pending

6 Could not be

Investigation

determined

examiner?

2 🗸 Accident

1 🗸 Yes

27. Manner of Death

Naturai

Suicide

Homicide

29b. Signature and title of certifier

1 Yes 2 No 9 V Unknown

UNPENDED

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause. Disease or injury that initiated.

failure List only one cause on each line

complications that caused the death.

Due to (or as a consequence of):

Due to (or as a consequence of): Due to (or as a consequence of)

23c. If yes, outcome of pregnancy

Pregnant at time of death

Inpatient 2

28a Date of Injury FOUND: Day, Year)

(Specify) Dwelling

Jul 3, 2006

mis

30 Name and address of person who completed cause of death (Item 23a)

a. Head Injuries

AMENDED

9

Live birth

Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

1

3

4

and attending physician After this

be detached for use as the burial page uneral director hours after death the f

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be

OCME 2006

To the Funeral Director:

31. Date filed (Month 1949, Year) 6 2006 State Registrar

Ling Li, MD

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature BLANCHE .

Fetal death

Other (Specify)

2

ER/Outpatient 3

FOUND:

0530 hrs

28e. Place of Injury - At home, farm, street, factory, office building, etc

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only).

28b Time of Injury

			For State	State of Maryland /	Department of Health and	Mental Hygie	ne2006	20995
	. S	-	Registrar 1. Decedent's Name (First, Middle, Las	0	Certificate of Death	Reg.	No.	3. Time of Death
	Physici		FIDRA	ELIZABET	H HADRIS	Month	Day Year	210 AM
	/Medi Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea	th	4c. County of Death	
				ealth of Wer	lea Baltimore		Na	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs, last)	birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min	, (Month, Day, Ye	coun	
	Director		Usual Residence of Decedent	71	113.	FEB 24,	1915 VII	RGINIA
	ryland how		10a. State 10b. County	10c. City, To	own or Location		1	0d. Inside City Limits
V	Ba-f s	ctor	MARYLAND N/	9	BALTIMOR	RE CIT	7/	1 Yes 2 □ No
2°	vith th	Director	10e. Street and Number	. 0	10f. Zip Code	10g.	ditizen of What Coun	try?
2	s 23a	era	6116 DELA	12. Was Decedent Ever in U.S.	2120	96	451	7
H "	fter de	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	14. Race - Americ Black, White,	
036	ours a	þ	3. Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2Æ.No Specify:		Specify: BL	ACK
Tora,	within 72 hours after deeth with the Maryland ene.	Completed by Funeral	15. Decedent's Ed (Specify only highest grad	ucation 16 de completed)	Sa. Decedent's Usual Occupation (Give kind of work done during most of wo	rkina 16t	. Kind of Business/Inc	lustry
121	within one.	Ig III	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of wo life. DO NOT use retired))	
	Hygie Hygie other	ပိ	3 RD G-RAOE 17. Father's Name (First, Middle, Last)	(UN KNOWN)	DOMESTIC WOR	me (First, Middle, Maid		AMILIES
A net	buld be Mental arked o	To Be			1 PHF	114	JENN	INCS
Marviand	2 should be filed within and Mental Hygiene. Is marked other then aurmatic event, the M	_	19a. Informant's Name/Relationship (T	vpe, Print)	9b. Mailing Address (Street and Number or Ri	ural Route Number, Ci		
	Pag 2 a			ES (DAUGHTER) 1	387 LIMIT AV	ENUE, B.	ALTIMORE	MD 21239
Baltimore	ges 1 tof H if ite		20a. Method of Disposition 1	acma	of Disposition (Name of tery, crematory or other place)		. Location - City or To	,
=	t. Par rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify,	NEU	22. Name and Address of Facility 2/	08-06 B	ALTIHORE	MARYLAND
<u>a</u>	permit. Pages 'Department of h Important: If ite eny Injury or ot		21. Signature of Funeral Service Lice s	(). (A)				
			23a. Part1. Enter the disease, or comp	lications that caused the death. D	Joseph H. Brown Jr. o not enter the mode of dying, such as cardia	correspiratory arrest	one baltin	nore IVID. Approximate
	Physician		Immediate Cause (Final	ne cause on each line.	111 201-TILV			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue to (or as a consequenc	e of):			
	Examiner	_	Sequentially list conditions,	b				
\/	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a consequent	⊕ JI).			
V	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c	e of):			
8760.	cate be e physician the buri	dical		d				
9		Medi	IS SOUND					
Вох	death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	th 3 Ectopic pregnancy		23d. Date of deliver	
o.	it the death by the atte	sici	1 Yes 2 No 9 Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)		Month i	Day Year
0.0	that the ed by detac		Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause given in Part I	23e. Did tobacc	o use contribute to the	a cause of death?
ds,	uires tha signed	d by	DEMENTIA	•	, , , , , , , , , , , , , , , , , , ,	1 ☐ Yes		ably 4 □Unknown
Ö	s been s should	olete	•			24a. Was an	24b. Were autop	sy findings available
Division of Vital Records,	Attending Physician: The law requires that the death certification death. sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Completed				autopsy performed	prior to com death?	pletion of cause of
ita	tician: T certificat rector, pa	Be C	25. Was case referred to medical examiner?	12.00	26. Place of Dea	1 ☐ Yes 2 ☑ th Check only one	No To res	Z NO
) t	Physic this ce al dire	္ရ	1 ☐ Yes 2 ☐ X	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence	6 □Other (Specify)	
o uc	Jing F	:lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b.	Time of Injury at Work?	28d. Describe how in	njury occurred	
isic	al or Attend after death Director: , d in by the (flcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home,	M 1 Yes 2 No	28f Location /Street	and Number or Rural	Pouto Mumbos
<u>o</u>	al or A s after I Dirse	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	ann, street, lactory, office	City or Town, St.	ate)	Houle Number,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in b		29a. Certifier 1 Certifying Phy (Check only) 2 Medical Exami	sician: To the best of my knowledge	ge, death occurred at the time, date and place	, and due to the cause	(s) and manner as sta	ited.
	ths H nin 24 the F nplete	Medical		and manner stated.	nd/or investigation, in my opinion, death occu	rred at the time, date a	and place, and due to	
	To To Con	2	29b. Signature and title of certifier	- ()	29c. License number	29d. [Date signed (Month, D	
	'n		1 merone	N	00060560	JU	LY 5, 2	2006
	1		PANICATION DATE TO PANICATION OF THE TENE	mpleted cause of death (Item 23a)	29c. License number D0060560 (Type, Print) - RIVEN NECK RI	·#1A9	RALTINA	2006 RE,MD
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 1 10		+1]- 1(14)	(() 1(2-1)
	Registr	ar	JUL 0 6 2	006 December St	GOOME)			

DHMH 17 Rev 1/2001

Registrar

6 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ^{Day} 2006 ALVIN ADAMS HAMMOND July 5, 10:45A [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 104 Cedarcroft Road Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) October 26, 1911 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2□ F 212-01-7282 94 Director Yrs. Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 ie marked other then "naturai", or items 23a or 28a-f ehow other treumatic avent, the Medical Examinar must be rictified at 10d. Inside City Limits XXXYes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Cedarcroft Road 21212 USA Completed by Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iten any injury or other treumatic avent, the Medical Examir at once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No White 3AAWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Alvin Hammond Elizabeth Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 69 Windbluff Court Owings Mills, Maryland 21117 David A Hammond Son 20a. Method of Disposition

XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Meadowridge Memorial Park 17/8/06 Elkridge, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc Jonnes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6500 York Road Baltimore Maryland 21212 Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, n any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit that initiated events resulting in death) Last Due to (of as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician d be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 HNO 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1□ Yes 1 ☐ Yes 2 ☐ No 2 7 NO To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospital: 1 Yes 2 ₩0 P 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28b. Time of Injury 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 SNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deati To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who converted cause of death (Item 23a) (Type, Print) 6569 N CHARLET ST#411 EGLEIN 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 0 6 2006 Registrar

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			David Ibrahimi, mp 10# 16616	7	13/2006						
	6		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	l/ a.	1201						
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06-04617 Jim Harman

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death Month Day July 1, 2006 **Medical Examiner** James Eugene Harman 1720 hrs 4a Facility Name (if not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death 2833 North Howard Street Baltimore none 5. Social Security Number 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY **Funeral** 9. Birthplace (State of Days Gountry) MD Months 053-62-8896 42 July 14, 196 Director 1^X M 2 F Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits iny Fla. Polk Mulberry Yes 2X X No 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 5225 Norris Lake Court 33860 U.S.A or items 23a or Funeral 13 Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married Yes White 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify Specify 'natural', ģ 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Completed it. Pages I and 2 should be now arment of Health and Mental Hygiene oorlant: If item 27 is marked other than "nat menimatic event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Computer Graphics Computers 18 Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Stanley Lee Harman Mary Louise Bradfield 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Passarella mother 5225 Norris Lake Ct. Mulberry, Fl 33860 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c Location - City or Town, State Department of He Important: If it in injury or other t Burial 2 X Cremation 3 Removal from State 7/3/06 Sykesville, MD County Crematory Donation 5 Other Specify 22 Name and Address of Facility nature of Funeral St 3871 Pike Columbia 21043 plack Funeral Р . A Home. Physician Pall I. Enter the dix air or complications that caus the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva List only one cause on each line Between Onset and /Medical Cardiomegaly Immediate Cause (Final disease ₹xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed gug Physician/Medical XUNPENDED X AMENDED item#1,23a,27,perME,g858,8/25/06 TT Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Year Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? After this certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 examiner? Other₄ Inpatient DOA Nursing Home 5 Residence 6 V Other. Scene ER/Outpatient 3 1 V Yes 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only one) To the l 2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. July 2, 2006 me 30 Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Month, Day, Year) Registrar's Signature State 0.6 Registrar

DHMH 17 Rev 1/2001 OCMF 2006